



DOCTORAL THESIS

An exploratory study of some of the ways in which psychiatric diagnosis may influence the way psychotherapists and counselling psychologists work

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**“An exploratory study of some of the ways in which
psychiatric diagnosis may influence the way
psychotherapists and counselling psychologists work”**

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Abstract

Psychotherapists and counselling psychologists may be provided with information regarding patients / clients prior to meeting them for the first time. The information provided may depend upon the setting where the therapists work, and can include a psychiatric diagnosis. This study explores the assumptions, within the literature, around the nature and impact of psychiatric diagnosis on patients / clients and on the clinician. The study then aims to look at ways, if any, that psychiatric diagnosis influences the way psychotherapists and counselling psychologists work.

Firstly, the study interviewed four psychotherapists using a semi-structured interview and the data was analysed using an Interpretative Phenomenological Analysis (IPA) as outlined by Smith *et al* (2009). The findings included that psychiatric diagnosis was an influencing factor as to whether to accept patients for therapy. In addition, a psychiatric diagnosis influenced the way in which they conducted the work, even when they were unaware of it.

Secondly, four counselling psychologists were interviewed later, using the same method as outlined above. The findings included that there are specific methods of working designed for different diagnoses. Economic pressures also emerged as a factor that appeared to influence the way psychiatric diagnosis was used.

The study went further, by exploring the possibility of utilising IPA to compare the data from each group. The researcher compared the similarities and differences

between the two groups based upon the findings obtained from the two separate IPA studies. There appeared to be more similarities than differences between the two groups, the main differences included the importance the psychotherapists placed upon the therapeutic relationship compared to the counselling psychologists and how the counselling psychologists spoke about economic pressures which influenced the way they work with psychiatric diagnosis whereas the psychotherapists did not.

CONTENTS

ACKNOWLEDGEMENTS	6
1. INTRODUCTION.....	7
2. LITERATURE REVIEW.....	14
2.1 Overview.....	14
2.2 Defining diagnosis.....	16
2.3 Defining psychiatric diagnosis	17
2.4 Literature supporting the use of psychiatric diagnosis.....	19
2.5 Literature against the use of psychiatric diagnosis.....	23
2.6 Literature taking a middle ground in relation to psychiatric diagnosis. .	40
2.7 Psychotherapy and the medical model.....	43
2.8 Previous research.....	53
2.9 Conclusion of literature review.....	54
3. METHODOLOGY.....	56
3.1 Considerations.....	56
3.2 Method for Interpretative Phenomenological Analysis.....	70
3.2.1 Selecting participants.....	70
3.2.2 Recruitment of participants.....	76
3.2.3 Consent.....	77
3.2.4 Potential distress.....	78
3.2.5 Confidentiality.....	78
3.2.6 Ethical approval.....	79
3.2.7 Data collection.....	79
3.2.8 Data analysis.....	80
3.4 Developing a method for using IPA as a comparison tool.....	83
4. FINDINGS.....	85
4.1. Overview.....	85
4.2 Findings for psychotherapists.....	86
4.2.1 Master table of superordinate themes	87
4.2.2 Wrestling with diagnosis.....	93
4.2.3 Influence of diagnosis.....	100
4.2.4 Impact on the formation of professional identity.....	106
4.2.5 Responsibility.....	112
4.2.6 Importance of the therapeutic relationship.....	113
4.2.7 Summary.....	115
4.3 Findings for counselling psychologists.....	117
4.3.1 Master table of superordinate themes.....	118

4.3.2 Wrestling with diagnosis.....	125
4.3.3 Influence of psychiatric diagnosis.....	143
4.3.4 Political and economic implications.....	151
4.3.5 Summary	158
4.4 Similarities & differences between the two groups.....	160
4.4.1 Cross reference table.....	161
4.4.2 Similarity & differences table.....	166
4.4.3 Similarities.....	168
4.4.4 Differences.....	177
4.4.5 Conclusion of the findings from the comparison study	183
4.5 Conclusion of findings chapter.....	185
5. DISCUSSION	186
5.1 Discussion of findings.....	186
5.1.1 Wrestling with diagnosis.....	186
5.1.2 Using diagnosis responsibly	189
5.1.3 Cannot escape influence	191
5.1.4 Direction of treatment / ways of working	192
5.1.5 Refusing patients	193
5.1.6 Training & experience	196
5.1.7 Direction of treatment	196
5.1.8 Economic pressure	196
5.1.9 The therapeutic relationship	198
5.1.10 Who can make a psychiatric diagnosis?.....	199
5.2 IPA within the study.....	203
5.3 IPA findings as a comparison tool.....	206
5.4 The role of supervision and personal therapy.....	211
5.5 Implications for practitioners and trainers.....	214
5.6 The researcher's role within the study.....	215
5.7 Suggestions for further research.....	221
6. CONCLUSION.....	222
7. BIBLIOGRAPHY.....	224

APPENDICES

Appendix 1. Consent form.....	213
Appendix 2. Debriefing document.....	215
Appendix 3. Ethics application.....	217
Appendix 4. Semi – structured interview.....	234
Appendix 5. Example of initial noting.....	228
Appendix 6. Example of emerging themes	235
Appendix 7. Example of clusters of emerging themes	238
Appendix 8. BACP email.....	241
Appendix 9. RCP statement.....	242
Appendix 10. BPS email (1).....	243
Appendix 11. BPS email (2).....	244

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1. INTRODUCTION

“An exploratory study of some of the ways in which psychiatric diagnosis may influence the way psychotherapists and counselling psychologists work”

This study is concerned with the implications, if any, that psychiatric diagnosis has upon the way psychotherapists and counselling psychologists work. The study is concerned with exploring whether the ways in which psychotherapists and counselling psychologists work could be influenced by the knowledge of any psychiatric diagnosis. In order to explore the lived experiences of the participants, the researcher chose to use a qualitative approach and selected an Interpretative Phenomenological Approach as outlined by Smith & Osborn (2008) as the research method. The study conducted two separate IPA studies; the first consisting of four psychotherapists and the second consisting of four counselling psychologists. Having completed the two IPA studies the researcher went on to explore the possibility of using IPA as a comparative tool, in an attempt to illuminate the similarities and differences between the two groups, in relation to the research question.

The research question came to light through the researcher's own experiences and struggle with his viewpoint on the use of psychiatric diagnosis. The researcher had worked in a non clinical capacity within private psychiatric hospital settings since 2005, in which all patients were seen by a psychiatrist and, if appropriate, a psychiatric diagnosis was made with treatments prescribed based upon the diagnosis.

The researcher worked for three different psychiatric hospital organisations and the procedure was the same with no deviation, all patients were initially seen by a consultant psychiatrist.

In 2009 the researcher embarked upon his own professional training in counselling and psychotherapy at the University of Roehampton. The first year of the course concentrated on person centred counselling and the work of Carl Rogers. The researcher recalls feelings of unease and confusion as there appeared to be strong emphasis upon the dangers of assessment and attempts to diagnose. There was prominence placed upon phenomenology, learning from experience and practice before theory. The researcher's only experience had been through the viewpoint of his work place, which upon completion of his training, he is able to realise took a medical perspective in relation to psychotherapy. During his training the researcher became interested in existentialism, psychoanalysis and postmodernism which has become influenced his theoretical orientation as a practitioner. Upon first glance the researcher believed these theoretical underpinnings took him further away from his work experiences, however, more recently, the researcher questions whether they too could be seen as a form of diagnosing, which is discussed. The researcher's professional training led him to question the use of psychiatric diagnosis. Continuing to work in a managerial role in a psychiatric hospital and having a consultant psychiatrist as one of his line managers led the researcher to feel confused as to how he was supposed to view psychiatric diagnosis. This, perhaps, led to a split in thinking; when at work seeing it one way, then during his training, viewing it in a different light. This led to feelings of unease and concern. The confusion and concern became more apparent during the first year of his training. The researcher

was working as a counsellor based inside a general practitioner (GP) surgery. One of the first people he was asked to see for counselling highlighted the confusion even further. The referral letter requested that the patient be seen for counselling following the loss of her mother, attached to the referral letter was a sticky note stating 'This patient has a history of PD [personality disorder] I understand if you don't want to see her'. Upon reading the referral letter and sticky note the researcher became aware of different feelings being evoked, wondering if this person could be helped by counselling and, also, raised anxieties surrounding seeing her. These thoughts included whether it would be appropriate for the researcher to see such a person and, also, what it would be like to be in a room with someone with this kind of psychiatric diagnosis. The researcher questioned how this may have been extremely unhelpful for the patient, the therapeutic relationship and to the counselling. This identified some of the feelings which emerged prior to seeing the patient. The researcher was also aware he had become increasingly anxious about ensuring the sessions started at exactly the time stated and felt more conscious about conducting the session in exactly the way he wanted. These feelings highlighted that the way the session was conducted was also influenced by the psychiatric diagnosis. The researcher also recalls that, for the first number of sessions, the psychiatric diagnosis seemed always present, however, after several weeks, it felt to the researcher that it had disappeared and his anxieties became less. This left the researcher curious as to why the psychiatric diagnosis provided had evoked such responses within him and to what extent did this hinder the counselling work. Therefore, the researcher was interested in hearing others' experiences, regarding to what extent, if at all, psychiatric diagnosis influences the way they conduct psychotherapeutic work. The researcher will be utilising his theoretical orientation

and training to help design and conduct the study and to analyse and discuss the findings. This may help to illuminate the subject and, possibly, allow the researcher to find his own viewpoint on the subject.

Historically, there appears to be a long standing and on-going debate with regard to psychiatric diagnosis within psychotherapy. Many authors, including Coulter (1979), Parker (1995), Boyle (2007) and Davies (2013), hold a strong position that psychiatric diagnosis is a hindrance to both practitioners and to the client. For example, Parker (1995) states “People living in varying degrees of discomfort or unhappiness are themselves transformed into categories, and modes of behaviour and thinking are then prescribed and proscribed for them” (Parker 1995 as cited in Feltham, 1999: 104). Whereas, contrary to this viewpoint, the number of different categories and classifications of psychiatric diagnosis has increased with every new edition of the Diagnostic and Statistical Manual (DSM) and there are many, including Ghaffari (2004) and Macaskill (1999), who defend the usefulness of psychiatric diagnosis within psychotherapy. Ghaffari (2004: 32) wrote “We firmly believe that a diagnostic assessment is an essential component of any comprehensive assessment for psychotherapy”, however, even though it is a strong statement to say that a diagnostic assessment is essential, it does not appear to be clear as to why he believes it is an essential component.

This study, therefore, is interested in investigating the debate surrounding psychiatric diagnosis further, with the literature review exploring some of the possible reasons why this may be so. The study is concerned with how the struggle may impact upon psychotherapists and counselling psychologists and, fundamentally, how psychiatric

diagnosis may, or may not influence the way in which they practice and the implications this may have for psychotherapy as a profession.

The literature review explores the definition of psychiatric diagnosis in an attempt to understand the subject being investigated. The literature review then investigates the different uses of psychiatric diagnosis within psychotherapy. The chapter explores the existing literature within the field, focusing on psychiatric diagnosis from different perspectives; commencing with literature identified from the position of being in favour of the use of psychiatric diagnosis, followed by literature appearing to be against its use, and then looking at the literature that takes a middle ground. The literature review then explores any existing research concerned with the way psychiatric diagnosis influences clinicians. Emerging from this, it appears there is little previous related research. One study highlighted a way in which psychiatric diagnosis can impact clinicians; Douglas *et al* (2005) interviewed educational psychologists and a significant finding asserted that the presence of a psychiatric diagnosis influenced the decision for a child's referral to specialist education services even though a psychiatric diagnosis was not to be considered as an influencing factor. Douglas *et al* (2005) does not provide any insight into the possible reasons for psychiatric diagnosis being an influencing factor. This study is concerned with the lived experiences of the participants, therefore, is interested in the possible reasons or motivations behind any ways in which psychiatric diagnosis influences the way they work.

The methodology chapter is concerned with the reasons for selecting the chosen method in relation to the research question. The chapter commences by exploring the rationale to use a qualitative method and continues to describe the reasons for not selecting specific methods. The chapter continues by exploring how the researcher is interested in the interpretative nature of phenomenology and how the study is concerned with taking the researcher's own experiences, as well as others, into account, which helped him come to the conclusion of using Interpretative Phenomenological Analysis (IPA) as the research method.

This chapter also considers how the researcher was interested in whether the findings from the analysis of the psychotherapists would be limited to those participants, or whether similar findings may emerge when investigating the same question in relation to different professions. An exploration as to the rationale for selecting counselling psychologists, as opposed to other professions, to compare with the psychotherapists is also provided.

The methodology chapter then presents the stages of the method used for this study, demonstrating how the ethical approval was sought in order to conduct the study, how participants were targeted, how the data was collected and analysed, and how the findings came to light. As IPA was conducted for this study, the researcher closely followed the approach outlined in the book "Interpretative Phenomenological Analysis Theory, Method and Research" (Smith *et al* 2009).

The chapter continues with the development of a method in order to compare the two findings from the two groups. This was based upon utilising the findings obtained from the two different IPA studies, in order to help identify similarities and differences between the two groups of participants. The stages of this method are then presented.

The Findings chapter presents the findings from the data analysis in three areas:

1. Findings from the data provided by psychotherapists. These included:
 - a. Wrestling with psychiatric diagnosis
 - b. The influence of psychiatric diagnosis
 - c. The impact on the formation of professional identity
 - d. Responsibility
 - e. Importance of the therapeutic relationship
2. Findings from the data provided by counselling psychologists. These included:
 - a. Wrestling with diagnosis
 - b. Influence of diagnosis
 - c. Political and economic implications
3. Similarities and differences between the two groups:
 - a. Two differences were identified
 - b. Six similarities were identified and explored.

A number of the findings that emerged from the analysis were then taken forward into the discussion chapter for further exploration. The discussion chapter discusses

these findings in relation to the literature on the topic, looking at the implications these have for the clinician, the client and for psychotherapeutic practice. The chapter discusses how the study may help illuminate two different ways of viewing the world, one from a positivistic standpoint and the other from a hermeneutic one.

The chapter then critically looks at the chosen method and at the limitations that IPA can bring, again, in relation to this specific question. In addition, the chapter explores the usefulness and limitations of using IPA as a comparative tool.

In this chapter the researcher attempts to revisit his motivations for conducting this study, how they may have impacted upon the findings and possibly the entire study. Finally, the chapter considers possible future research that this study may have helped inform.

2. LITERATURE REVIEW

2.1 Overview

The researcher utilised three main databases for the literature review. These were pep-web.org, Ebscohost and Springerlink. The search terms used were: diagnosis in psychotherapy, psychiatric diagnosis in psychotherapy, effects of diagnosis, implications of diagnosis, implications of diagnosis for psychotherapy, psychiatric diagnosis, implications of psychiatric diagnosis, diagnosis helpful, diagnosis hinder, psychotherapy, definition of psychiatric diagnosis, diagnosis in counselling, counselling and psychiatric diagnosis, diagnosis in psychology, diagnosis in counselling psychology, psychiatric diagnosis in counselling psychology, psychiatric diagnosis in the talking therapies, psychology and psychiatric diagnosis, psychology, psychotherapy and psychiatric diagnosis, working with psychiatric diagnosis, working without psychiatric diagnosis, qualitative comparison studies, comparison, IPA, Comparing IPA studies.

The literature review commences with an investigation into the definition of diagnosis and psychiatric diagnosis in order to better understand the subject which the study is aiming to illuminate. This also aims to highlight the different uses of psychiatric diagnosis within psychotherapy. This chapter continues to explore existing literature surrounding psychiatric diagnosis from the position of those in favour of, those against and those who take a middle ground, in relation to the use of psychiatric diagnosis within psychotherapy. The literature review aims to explore

any existing research surrounding psychiatric diagnosis and its influence on clinicians.

2.2 Defining diagnosis

In order to help illuminate the question being investigated in this study, the researcher chose to explore what is meant by diagnosis, then to look at how the word has been placed after the word psychiatric in order to produce the term 'psychiatric diagnosis'.

The Oxford English Dictionary (2010) provides two meanings to the word diagnosis:

1. The identification of the nature of an illness or other problem by examination of the symptoms.
2. The distinctive characterisation in precise terms of a genus, species, or phenomenon.

The researcher felt the differentiation between these two meanings was important to acknowledge. The vast and overwhelming array of literature, regarding diagnosis, focused on the identification of the nature of illness. The word diagnosis, according to the Encyclopaedia Britannica (2001) is “the process of determining the nature of disease or disorder and distinguishing it from other possible conditions. The term comes from the Greek *gnosis*, meaning knowledge”. This related to the first definition provided by the Oxford English Dictionary rather than the second. The first definition could be seen as being aligned to a positivistic viewpoint with

predetermined criteria in which to be measured against. The second definition could be viewed as a more hermeneutic position, more concerned with people's experience. The researcher, however, identified little literature in relation to 'genus' or to 'species' and even less so to the characterisation of phenomenon.

2.3 Defining psychiatric diagnosis

The researcher could not find a specific definition for the term psychiatric diagnosis therefore chose to break down the two words. The word psychiatric according to the Oxford English Dictionary, is "Relating to mental illness or its treatment". The researcher felt that by adding the word psychiatric before the word diagnosis takes us further away from the second possible meaning the Oxford English Dictionary provides for the word diagnosis; as 'mental illness' does not fit well with the words genus, species or phenomenon.

Therefore, when the word psychiatric is combined with the word diagnosis the researcher believes the definition of the phrase would be akin to 'The identification and treatment of the nature of mental illness by examination of the symptoms'. This seems to indicate the reasons why specific classifications of mental illness may have emerged in order to be able to look at a set of symptoms to make a psychiatric diagnosis.

The two largest current classifications of mental illness are:

- Diagnostic Statistical Manual of Mental Disorders (DSM) compiled by the American Psychiatric Association (APA)
- International Classification of Diseases (ICD) compiled by the World Health Organisation (WHO).

Even though there are two main bodies for the classification of mental illness, a statement from the DSM's own website shows that they work closely together, implying there is only one main viewpoint on mental illness:

“DSM-5 and the ICD should be thought of as companion publications. DSM-5 contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The ICD contains the code numbers used in DSM-5 and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies. The APA works closely with staff from the WHO, CMS, and CDC-NCHS to ensure that the two systems are maximally compatible” (DSM5.org, 2014).

The fact there is two definitions of diagnosis opened up a question surrounding other uses of diagnosis within the talking therapies. Looking at the second description of diagnosis, provided by the Oxford English Dictionary as mentioned above, led the researcher to wonder whether this could fit with certain clinicians working within psychotherapy. Clinicians may say they do not use diagnosis although, perhaps, they mean they do not use psychiatric diagnosis as in the term discussed above. ‘The

distinctive characterization in precise terms of a genus, species, or phenomenon' may seem to fit with how some talking therapies of many different orientations work. The researcher believes this sentence could also be interpreted as diagnosis being 'the distinctive description in detailed terms of a phenomenon or experience'. This fits more with a phenomenological view of diagnosis and, possibly, with how some practitioners sit with diagnosis. This study is concerned with, to what extent, if at all, psychiatric diagnosis influences the way in which psychotherapists and counselling psychologists work, therefore, acknowledges the fact that different professions within psychotherapy may have different interpretations of the word diagnosis and even possibly the term psychiatric diagnosis.

2.4 Literature appearing to be in support of the use of psychiatric diagnosis

Macaskill, as quoted in Feltham (1999: 117), defends the position and usefulness of diagnosis within mental health as he argues on the discussion of diagnosis that "...the potential advantages and benefits for patient, therapist and society have rarely been argued or acknowledged". Macaskill provides a number of reasons why diagnostic labelling can be useful. Firstly, he shows how a diagnosis actually provides a name to the patient for something that has been experienced as frightening. Secondly, how the patient's symptoms and behaviours, when explained in an understandable and meaningful manner, in itself reduce the fear of the unknown, which in turn will provide relief from the discomfort the patient is facing. Macaskill also shows how diagnosis can 'normalise' how someone is feeling and that they are not alone with their symptoms. He cites a quotation from Yalom (1970:

70) “others are in the same boat” to show that the realisation that one is not alone with specific symptoms and feelings is a powerful psychotherapeutic tool in itself. Other reasons Macaskill provides for the helpfulness of diagnosis for patients include how the identification and naming of a set of symptoms can take away the blame towards some moral, spiritual or character weakness that patients can inflict upon themselves. Also, the systematic approach to classifying the symptoms of distress, by the clinician, helps to strengthen the therapeutic relationship thus helping the patient. In addition to the benefits for the patient, Macaskill argues that by providing a diagnostic label to the symptoms faced by a patient empowers the patient to, potentially, be able to access helpful resources specifically designed for those symptoms. Furthermore, Macaskill reflects on the usefulness for the clinician, whether it is for a psychiatrist, psychologist or therapist. Firstly, he argues that a strong understanding of psychopathology enhances the credibility of the therapist and the patient feels more understood. Another benefit outlined, is how a clinician, with a strong diagnostic background, could look for problems the patient has not been able to speak of, whether deliberately or not, for fear of being labelled as ‘mad’. Another reason provided by Macaskill (as quoted in Feltham 1999: 119) is that diagnosis enables “effective treatment planning”.

A book written by a psychiatrist who is also a psychotherapist expresses the importance of diagnosis and assessment, Ghaffari (2004: 32) writes: “We firmly believe that a diagnostic assessment is an essential component of any comprehensive assessment for psychotherapy”. Ghaffari goes on to state in the same paragraph “For example in the assessment of young people for psychodynamic psychotherapy, diagnostic factors have been found to be important as predictors for suitability for

psychotherapy”. Here Ghaffari talks about this usefulness of diagnostic assessment, which will often include a psychiatric diagnosis in order to determine the treatment plan. Even though he advocates the use of diagnostic assessment he is also mindful of the limitations and the implications. Later on Ghaffari (2004: 34) states:

“In reaching a diagnosis, it is important to avoid focusing on the manifest symptoms alone. It is pertinent to consider those symptoms as a form of communication within the context of different dimensions, including developmental and personality factors, social culture, and environmental conditions”.

Ghaffari seems to be saying that diagnosis can be a useful tool, however, it also can have the power to influence treatment if one is not careful and mindful of that fact. The researcher wondered whether this view that diagnosis is important, yet can be dangerous, could be influenced by the two sets of training that Ghaffari had experienced, one from a psychiatric background and one from his psychotherapeutic education.

Upon writing about the importance of case history in psychotherapy Thorne (1945: 319) states “It seems elemental that rational treatment cannot be planned and executed until an accurate diagnosis has been made”. This statement suggests that diagnosis is essential to effective psychotherapy, however, Thorne does not totally rely upon the diagnosis as he continues:

“It is occasionally possible to make a snap diagnosis through recognition of pathognomonic signs or clinical intuition, but the experienced clinician knows that such diagnoses are more often erroneous than true”
Thorne (1945:319).

Thorne also goes on to state “it should be obvious that there are no shortcuts to clinical understanding”. Therefore, even though Thorne believes that diagnosis is imperative to effective psychotherapy, the relationship with the patient exploring their unique story is an essential part of therapy and that diagnosis can often be incorrect and could close down other possibilities for the client. For Thorne there appears to be limitations as well as benefits with respect to the role of diagnosis, which the researcher found of interest. One interesting piece of literature stated that:

“For may (sic) person-centred practitioners in continental Europe ‘assessment’ is not at all problematic. Here, the language of psychiatry and medicine seems to sit a lot more easily with person-centred practice than it does in the UK or the USA” (Joseph, 2005: 131).

This suggested the attitude of person-centred practitioners varied and made the researcher question why this could be so; could there be training differences or is the use of assessment and diagnosis different in other countries? Another possible answer could be in the way the pharmaceutical industry often has a specific medication for each psychiatric disorder and whether this also may play a part.

2.5 Literature written opposing the use of psychiatric diagnosis

Rogers (1946:420) provides another person centred perspective regarding psychiatric diagnosis: “diagnostic knowledge and skill is not necessary for good therapy”. This suggests that diagnosis and questioning to look for a possible psychiatric diagnosis is not essential for good therapy to take place. It does, however, ask the researcher to consider what is meant by ‘good therapy’. This statement, nonetheless, does not show Rogers’ feelings whether it is beneficial or not, simply that it is not essential. Writing about Rogers, Dryden (2007: 145) stated:

“Diagnosis and interpretation are far removed from the primary concerns of a contemporary person-centred therapist and in an important sense Rogers’s progressive disillusionment with both these activities during his time at Rochester marks the beginning of his own unique approach”.

To the researcher, this suggests that Dryden is explaining how Rogers’ own approach, was derived through aspects of his unhappiness with the existing approaches, which included the importance of psychiatric diagnosis within therapy. Upon writing on a specific case study, Rogers commented:

“This incident was one of a number which helped me to experience the fact – only fully realised later- that it is the client who knows what hurts, what direction to go, what problems are crucial, what experiences have been deeply buried. It began to occur to me that unless I had a need to demonstrate my own cleverness and learning, I would do better to rely

upon the client for the direction of movement in the process” (Rogers 1979 as cited in Kirschenbaum 1989: 13).

This suggests Rogers’ new way of thinking at the time was how he believed it is more important to understand the person who is sitting opposite him rather than trying to treat a diagnosis that has been given or hypothesized. It also implies that a possible motivation for the use of psychiatric diagnosis is to show that the clinician is in a position of power derived through his learning and so puts the clinician in a position of authority over the client.

On the role of assessment Corey (2005: 186) writes:

“In the early development of nondirective therapy, Rogers recommended caution in using psychometric measures or in taking a complete case history at the outset of counselling. If a counselling relationship began with a battery of psychological tests and a detailed case history, he believed clients could get the impression that the counsellor would be providing the solutions to their problems”.

Corey is showing how taking a case history or assessing someone can be used to express that something is wrong with someone which implies that if there is something wrong then it can be fixed. Even though Corey was writing case history rather than diagnosis, often a psychiatric diagnosis is constructed by the clinician extensively looking at the history of the patient and by conducting tests. Corey goes on to write “Functions such as diagnosis and assessment often grant priority to the

practitioners 'truth' over client's knowledge about their own lives" (Corey 2005: 413). This also leads one to question whether it is possible for a person to believe they are unwell based upon a person in perceived authority inferring there is something wrong with them. Scheff (1966) wrote in depth regarding this subject with a view that this can ultimately lead to someone becoming unwell and mentally ill.

The researcher believes one of the most prominent objections to the use of diagnosis for Rogers is the way in which it can impede the therapeutic relationship. Rogers (1951: 222) writes:

"In order for behaviour to change, a change in perception must be experienced. Intellectual knowledge cannot substitute for this. It is this proposition which has perhaps cast the most doubt upon the usefulness of diagnosis".

This is echoed by another author, Arbuckle (1961) as cited in Sanders, (1974: 253) when writing about person centred counsellors he states he:

"...is sceptical about the capacity of a counsellor to relate closely and intimately with another person and at the same time be functioning as a diagnostician of that individual's problems and difficulties"

Arbuckle describes how diagnosis has the ability to impair the way in which the therapist and client participate empathetically within the relationship. This may provide an understanding for Rogers' (1951: 223) statement that:

“In a very meaningful and accurate sense therapy is diagnosis and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician”.

Rogers is showing how the client is the expert on themselves and knows what needs attention in the therapeutic encounter, therefore the clinician can be counterproductive by interjecting a psychiatric diagnosis into the work, due to the fact that this may take the focus away from what is important to the client.

Moving away from a person centred counselling perspective, Laing, who was instrumental in the anti-psychiatry movement, was concerned with the way the labelling within psychiatry concentrates too much on people's behaviour instead of on their experiences “We can see other people's behaviour but not their experiences” (Laing, 1967: 17). Another interesting view of psychiatry from Laing was in his critique of Freud's work :

“This difficulty faces not only classical Freudian metapsychology but equally any theory that begins with man or a part of man abstracted from his relation with the other in his world” (Laing, 1960: 19).

This shows that Laing expressed concerns over the way in which diagnostic theory can concentrate on the person without taking into account the way in which that person is within his specific world. Laing implies that we could be concentrating on the way clients are behaving in that moment, not taking into account their experiences and, from that behaviour, providing a psychiatric diagnosis which, therapy then attempts to 'treat', taking the therapist away from attending to the client's experiences, which have contributed to their behaviour.

Speaking about diagnosis from a more contemporary perspective and how diagnosis is classified, Marzillier (2004: 392) writes:

“The lines drawn to distinguish different psychiatric conditions are far from firm. There is a huge overlap of symptoms between so-called illness, most obvious when in 1974 members of the American Psychiatric Association voted that homosexuality should no longer be in the DSM lexicon”.

Marzillier is stating a number of important aspects about diagnosis; firstly, how the symptoms used to classify specific disorders can overlap other disorders, secondly, by stating that the lines drawn to distinguish different psychiatric conditions are far from firm, shows there is no definitive way to diagnose a psychiatric disorder as it is subjective to the moment and to the person making the diagnosis. Thirdly, Marzillier provides an important example of how a psychiatric disorder can be subject to time. The example given shows that on one specific day someone would be diagnosed as mentally ill with a psychiatric condition as outlined in the DSM of the day and the

very next day they are no longer mentally ill although nothing for that person changed. This point opens up a different aspect with regard to psychiatric diagnosis, one of social and political importance. Jutel (2011: 8) writes:

“During the preparation of the DSM-III, gay activists adamantly objected to homosexuality’s then-categorisation as mental illness. They sought public acknowledgement of their position via disruptive protests at the American Psychiatric Association conventions. The cumulative effect of their collective action was compounded by media attention and the personal ambition of the chair of the committee appointed to oversee the DSM revision process and resulted in the removal of homosexuality as a diagnostic category”.

The vote to remove homosexuality from the DSM was 55% of the voters in agreement to remove it. This shows that, even at that time, only just over half of the people responsible for deciding what disorders are classified, agreed that it was no longer a disorder. This suggests the reason for this psychiatric condition to no longer be a condition is not that a ‘cure’ was found, or that it was agreed that the previous members of the American Psychiatric Association who compiled the last DSM were wrong, rather that it was due to public pressure.

Another important aspect to acknowledge regarding the removal of homosexuality from the DSM is that it echoes Laing’s views that psychiatric diagnosis can ignore people’s experiences as the APA gave a reason for the removal being “The crucial issue in determining whether or not homosexuality per se should be regarded as a

mental disorder is not the etiology of the condition, but its consequences and the definition of mental disorder” (American Psychiatric Association 1980). Spitzer *et al* (1973: 1216) provides an example of how the effects on homosexuals being classified as psychiatrically unwell impacted upon their lives:

“In the past homosexuals have been denied civil rights in many areas of life on the ground that because they suffer from a mental illness the burden of proof is on them to demonstrate their competence, reliability, or mental stability”.

The reclassification of homosexuality also suggests there is a concern it is possible to ignore people’s experiences and, instead, label them with a diagnostic classification in order that we can correct their behaviour to fit in with what is deemed acceptable at that specific moment in time. Marzillier (2004) explained that some of the experiences which contribute to people being diagnosed as mentally unwell are experiences which everyone can have at some stage and in some form.

Cooper (2005: 18) states:

“The introduction to the DSM III (American Psychiatric Association, 1980) includes the following definition of mental disorder ...each of the mental disorders is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom or impairment in one or more areas of functioning. In addition there is an inference that there is a behavioural, psychological, or biological dysfunction, and that

the disturbance is not only in the relationship between the individual and society”.

Cooper, here, implies that the classification of mental disorder must not only be connected between the individual and what is going on politically and socially, but there must be something else dysfunctional within the person.

Boyle (2007: 290) points out how diagnosis has hindered our understanding of behaviour and experience because:

“the idea that diagnosis identifies mental disorders which may become objects of study has created theoretical and practical divisions between ‘normal and abnormal’”.

Boyle continues to question why we are still holding on to the usefulness of diagnosis as she feels it is a flawed system that lacks any scientific basis and states:

“no aspiring science has ever been successful by asserting at the outset what kind of patterns it will observe and retaining this belief in the face of decades of unsuccessful research. Yet this is exactly what has happened in psychiatry”.

Boyle does mention how diagnosis can sometimes be useful for patients when she states:

“Of course, people may be helped or comforted by a diagnosis” but she carries on in the same sentence to demonstrate how this can also be a hindrance “they may (rightly) believe that a diagnosis means that some aspect of their problem has been encountered before or (wrongly) believe it explains their distress or predicts its outcome or that it excludes something worse” Boyle (2007:291).

Here, Boyle is showing how diagnosis can close down possibilities and can be detrimental to the client. In an attempt to provide some rationale as to why we are still using diagnostic systems she provides a very interesting argument that there is an ever increasing symbiosis between the people responsible for devising the diagnostic concepts and the pharmaceutical industry “drug marketing is strengthened if there appears to be a specific disorder the drug can target” (Boyle 2007:292). This may seem extremely clear and understandable, but also demonstrates a rationale as to why diagnosis continues to be used and how, unfortunately, this situation could be open to abuse. Another reason, as highlighted by Boyle (2007), is the way in which diagnosis can be used to maintain the position of psychiatry within the medical world as this enables “‘normal’ people to locate irrationality in others in a society that reveres rationality, seeming to solve problems of blame and responsibility and distracting attention from the harmful psychological consequences of social and political policies and structures” (Boyle, 2007: 292). She is showing how diagnosis provides an acceptable reason for others’ behaviour without actually looking at other aspects which could be fundamentally important to why that person is not appearing ‘normal’. So, once again, Boyle is showing how diagnosis can close down

possibilities but furthermore, how it can provide a scapegoat for blame, distracting people from actually looking at what is possibly going on socially and politically.

The close relationship between the pharmaceutical companies and psychiatric diagnosis is also picked up by Aho who cites the former editor of the New England Journal of Medicine, stating that “the medical profession is being bought by the pharmaceutical industry not only in terms of the practice of medicine, but also in terms of teaching and research” (Relman as cited in Aho 2008: 244). Aho also goes on to state the view that clinicians are interpreting everyday suffering and behaviours not as that, but as medical conditions that can be treated with medication. Aho explains how diagnostic thinking is only concerned with the behaviour which is observable and how the behaviour fits into the specific categories within the DSM, Aho calls this process “dehumanizing” as it does not allow the patient to express how this behaviour manifests in their being in the world. Aho provides a different approach to diagnosis which is more phenomenologically based and Aho (2008:247) believes this would:

“challenge the disease model by remaining faithful to the illness, where illness is understood as the lived experience of the patient and how she/he exists with, makes sense of, and responds to the symptoms”.

Aho continues and quotes Heidegger to help explain this “the corporeal [body] stops at the skin but the lived-body is ec-static – it is already woven to the world in the course of everyday acts and practices”. Aho carries on showing that from the phenomenological lived body experience the evidence of mental disorders is not

“objective and quantifiable”. Also, that moods should not be seen as effects which are only contained within the individual, but emerge within the social context as well. Therefore, experiences of psychiatric diagnosis such as depression are perhaps more than a condition which the medical model has classified.

In a journal article Cox, (2010: 27) expresses his views on state regulation of psychotherapy published in June 2010, in which he writes that the regulation is seeking to standardise all psychotherapy into a medical model. Whilst writing on the subject of diagnosis, Cox cites Yalom (2001: 4) stating that he urges psychotherapists to avoid diagnosis “It has precious little to do with reality. It represents instead an illusory attempt to legislate scientific precision into being when it is neither possible nor desirable”. Cox describes the medical model as an:

“ABC approach, where A is diagnosis, B is treatment and C is cure. The patient is recognised as being sick and, according to the presenting symptoms, given a diagnosis. The sick person is in need of an expert who will prescribe treatment, and the treatment will affect the necessary cure” (Cox as cited in Rowland 2002)

Rowland (2002) carries on to cite Cox “diagnosis does not take into account the person’s process of feeling and function”. Another quote from Cox helped shape this study and impacted upon the researcher’s targeting of potential participants. “Freeth (2007: 31) states assessment, diagnosis and treatment are at the heart of the medical model. This is at odds with relationship-centred psychological therapies – and raises many questions for those working in healthcare settings”. This quote highlighted the

importance for the study to include psychotherapists who work within healthcare settings such as psychiatric hospitals as well as those who do not.

The literature found a standpoint that many took, that there are significant differences between physical diagnosis and psychiatric diagnosis, Coulter (1979:149) states “Psychiatric practices are not poor cousins of physical diagnosis, for they do not belong to that family of practices, however medical are some of the consequences”. Coulter writes about how physical diagnosis comes from applying biological knowledge whereas the formulation of mental illness cannot be made using scientific methods. Scientific methods are supposed to be objective and independent of context, however Coulter writes that psychiatric diagnosis cannot do this. Instead, someone is deemed as mentally unwell when their behaviour goes against the social norms of intelligibility. “It is a response to mundane social and moral requirements and not to the development of some esoteric branch of knowledge” (Coulter 1979:150).

An important aspect for the researcher to also look at during this literature review is the effect of diagnosis upon the individual and the implications this may have for the client:

“People living in varying degrees of discomfort or unhappiness are themselves transformed into categories, and modes of behaviour and thinking are then prescribed and proscribed for them...It would seem from social trends in North America even mild states of depression that all of us sometimes experience will soon be suppressed with drugs.

Diagnosis brings with it dehumanization, labelling, the pathologization of many human activities and iatrogenesis” (Parker (1995) in Feltham, 1999: 104).

The above passage highlights some of the effects of psychiatric diagnosis, especially that patients can be labelled with a diagnosis and what that specific diagnosis means to the patient, also what it means to clinicians and to what extent it impacts on their perception of the patient.

Parker (1995: 106) provides a strong argument for deconstructing diagnosis with an example being:

“Those who are so intent upon fixing pathology in others can themselves be ‘diagnosed’ as suffering from an obsession with order and with arranging people in a set of a categories”.

This way of thinking shows how the relationship between the person who is diagnosing and the person who is diagnosed can be reversed. This example highlights an important issue that the whole system of diagnoses can unravel quite easily if thought out differently. In addition to his arguments regarding diagnosis, Parker (1995: 109) also points out a dilemma which faces counsellors and therapists

“Diagnosis is a crucial issue for counsellors and psychotherapists, for they are brought face to face with a moral-political choice about where their allegiance should lie”.

Parker explains that often counsellors use diagnostic thinking and tools to “...please the bureaucrats who like official records organized around certain categories”. This position is reinforced by Loewenthal (2007: 130):

“For some therapists being identified as a health professional is seen as giving them a status they deserve; yet for others any notion of a medical model defeats the purpose of the therapy”.

This possible struggle is also echoed by Dudley (2004: 14) who writes “I work hard not to use psychiatric language and terminology but fail to achieve this most days” Dudley continues to talk about how the prominent language within her work setting is psychiatry and states “I am aware of my wish to belong, to feel connected to the main influential group and to experience the power and connection that such belonging gives”.

Tamimi & Radcliffe (2005: 64) wrote:

“Despite the assertion from ADHD industry insiders that ‘ADHD’ is a medical disorder, even they have to concede that despite years and millions of dollars spent on research (it is the most thoroughly researched child psychiatric label – from a biological perspective that is) no medical test for it exists, nor has any proof been forthcoming of what the supposed physical deficit is, and so diagnosis is based on the subjective opinion of the diagnose”.

The above passage opens up the debate as to whether there is evidence for biological aspects for all other psychiatric disorders; on the literature surrounding schizophrenia, Boyle (2007:9) looks at how there is a strong belief that schizophrenia is a brain disease, although there is a large discrepancy between this view and any supporting evidence, and asks the question “how is the presentation of ‘schizophrenia as a brain disease’ managed in such a way that the absence of direct evidence will not be noticed or not seem important?” Davies (2013) continues the investigation into whether there is biological evidence behind psychiatric disorders. He identifies there is very little evidence and quotes a conversation between himself and Spitzer, one of the members of the task force responsible for the production of the DSM IV;

“There are only a handful of mental disorders in the DSM known to have a biological cause. These are known as the organic disorders [things like epilepsy, Alzheimer’s and Huntington’s disease]. These are few and far between” (Spitzer as cited in Davies 2013:22).

One aspect that seemed to emerge from the literature review is in relation to what can occur when someone is provided with a label of being mentally unwell which a psychiatric diagnosis can do. Scheff (1966) provided the idea that being labelled as mentally ill can cause that person to be mentally ill. Labelling theory can be seen as the theory of how self identity and therefore people’s behaviour can be influenced and possibly determined by the words used to classify and describe them. Scheff challenged the medical model notion that mental illness may not be a disease but a

role within society. The term 'residual deviance' used by Scheff (1966) was to help define the violation of societal norms that the majority, and those in control, have dictated as so. This could lead to those not acting according to such norms to be seen as unnatural and, possibly a manifestation of the so called mental illness. According to Scheff, being labelled with a mental illness and so being labelled as mentally ill, leads to another secondary deviance reinforcing their behaviour as unacceptable and can lock the individual into a lifetime of so called deviance. According to Ruscio (2004: 3) "labelling theory predicts that individuals with sufficient resources to forgo hospitalization for mental illness should do so to avoid the secondary deviance caused by labelling".

Upon writing regarding labelling theory Kroska and Harkness (2008: 326) state:

"The negative consequences of psychiatric labelling arise through two social psychological processes. First, when an individual is diagnosed with a mental illness, cultural ideas associated with the mentally ill (e.g. incompetent, dangerous) become personally relevant and foster negative self-feelings. Second, these personally relevant cultural meanings are transformed into expectations that others will reject the individual, expectations that trigger defensive behaviours aimed at preventing that rejection: concealing treatment histories, educating others about mental illness, and / or withdrawing from social interaction".

Thus, the workings within labelling theory seem increasingly important to today's diagnostic criteria with the ever growing number of psychiatric illnesses and the

increase of prescription medication to cure this illness. Rosenfield (1997) highlights the fact that there is another side to the argument and that labelling theory and its implications on mental health has both benefits and problems associated with it.

Rosenfield (1997: 667) writes:

“In sum, the contrasting views of stigma offered by labelling theory and its critics imply opposite effects of psychiatric labels: Labelling theorists predict destructive outcomes, while psychiatric theorists claim beneficial results. Past research has found evidence for both positive and negative effects of labelling”.

Some of the authors whose opinion of labels within mental health is one of a positive stance include Gove (1970) and Cockerham (1979). Gove (1970:291) writes:

“The vast majority of persons labelled mentally ill are seriously impaired and their impairment is the major reason for labelling . . . labelling is not a major factor in a chronic career of mental illness but, in fact, labelling tends to initiate processes that minimize the length and severity of a person’s disorder”.

Therefore, there appears to be an ongoing debate regarding the use of labelling just as the literature suggests there is an ongoing debate regarding the use of psychiatric diagnosis.

2. 6 Literature which appears to take a middle ground with regard to the use of psychiatric diagnosis

On writing, prior to the latest edition of the DSM being released, Jackson (2012) highlighted the current divide in opinion within the healthcare profession regarding psychiatric diagnosis. Jackson states that by April 2012 12,800 people had signed an international, online petition against the draft of the DSM5. Jackson describes the main criticisms of the draft DSM5 as extending the number of psychiatric diagnoses even further and many would feel that psychiatric diagnoses has been applied to what could be considered “normal ranges of human emotion and behaviours” and that it ignores other factors which could contribute to mental illness except neurological and biological ones. Jackson (2012: 6) explains this further as she writes “by locating the problem in the individual, the BPS argues medical diagnostic systems such as the DSM overlook potential social and environmental causal factors”. This echoes the words of Laing back in the 1960’s about only seeing other people’s behaviour and not their experience. Another significant aspect is that Jackson states criticism is also coming from the psychiatric profession; she quotes Professor Nick Craddock from Cardiff University who points out that the idea of psychiatry is there are normal and abnormal experiences and that if you can recognise the abnormal ones then you can help. Craddock goes on to provide an example of how the DSM5 is attempting to remove aspects of experience which could be seen as essential aspects of everyday living. The revision of bereavement in the latest edition of the DSM removes a four month window that was present in previous editions which stated only after four months had passed, if the person was still experiencing symptoms of low mood, should they be referred for psychiatric

treatment. When explaining this change Craddock states “That is a change that moves us towards medicalization and that is something most psychiatrists don’t agree with” (Craddock as cited in Jackson 2012: 7). Even though Craddock seems to be opposed to these changes he mentions how it is a necessity in today’s society to use such labels due to the fact that insurance companies pay for the majority of all health treatment “In the US, if a professional wants to help someone, they need to label the problem as something that justifies giving the help” and he warns that the UK will probably follow this route as well with the introduction by the NHS of payment by results. This does not show how Craddock is in favour of a system of labels rather than it is a necessity in today’s society and culture. Jackson continues on the dangers of the DSM-5 and states “The New Scientist recently reported that more than half the individuals in the DSM-5 Task Force have some financial link with the pharmaceutical industry” (Jackson 2012:8). This reiterates the words of both Boyle and Aho as mentioned previously.

Looking at psychiatric diagnosis from a different perspective, Roudinesco (2001:24) argues that dynamic psychiatrists used to hold a view of psychiatric diagnosis which focused on four models to explain the human psyche :

“a nosographic model arising from psychiatry and enabling both a universal classification of illness and a definition of clinical practice in terms of norms and pathology; a psychotherapeutic model inherited from the ancient healers and assuming that therapeutic efficacy is linked to a power of suggestion; a philosophical or phenomenological model making it possible to grasp the meaning of the physical or mental trouble

starting from what is lived and existential (both consciously and unconsciously) for the subject; and a cultural model explanation of humanity based on social context or difference”.

The position written by Roudinesco provides a different look at diagnosis and is one that rejects the tendency of psychiatrists, who seem to be surrounded by the constant growth of psychopharmacology who have therefore, abandoned the above model in favour of the DSM classification of forms of behaviour. It is also interesting to see that Roudinesco (2001) states that fifty percent of psychiatrists in France also practice psychoanalysis, which asks the question why is France, as according to Vallee (2011) one of the largest consumer of psychiatric medication in the world and the largest European consumers of antidepressants? Vallee (2011: 95) goes on to state that French psychiatry does not imitate the biological reductionism that is readily found in the United States, instead:

“French psychiatry has evolved toward an eclectic approach, which draws on psychoanalysis, phenomenology and psychopharmacology and where clinicians are not interested in mental illness per se, but rather in the sick who have to be approached in their entirety, in their singularity and in their history”.

Vallee (2011) also continues to describe how the DSM – III’s approach was too different from the diagnostic process used by the majority of psychiatrists in France. The concern, according to Vallee et al, was that the DSM –III’s approach towards

the diagnoses of children and adolescents focused on isolated symptoms and did not take into account structural psychopathological configurations. This led to the French Federation of Psychiatry developing their own classification system for child and adolescent mental illnesses called the CFTMEA which was released in 1983 and updated in 1988 and 2000. This difference in classifications and, therefore, so called treatments may help to explain that, according to Vallee, nine percent of school aged children in America are diagnosed and taking medication for ADHD, compared to 0.5 percent in France. Wedge (2012) writes that French psychiatrists are more concerned with understanding the underlying reasons for the child's distress rather than a biological disorder with biological causes. This opens up the conversation regarding the evidence surrounding whether there is a biological disorder associated with ADHD.

An interesting position appears to be adopted by the Psychologist magazine. Volume 20 in 2007 was a special edition dedicated to promoting their position "to move beyond psychiatric diagnosis" (Cromby, 2007: 289). This emphasises the position of the magazine that there are concerns regarding psychiatric diagnosis, and again echoes many author's concerns regarding the use of diagnosis, however, does not seem to provide what they mean by moving beyond psychiatric diagnosis. The researcher questions where this leaves psychologists in relation to diagnosis, if they desire to move away from it, but are not sure to where this would lead them.

2.7 Psychotherapy and the medical model

The literature review has identified an ongoing debate with regard to the use of psychiatric diagnosis. The Oxford English Dictionary, as mentioned previously, defines the word psychiatric as “Relating to mental illness or its treatment”. The fact that the definition includes the words ‘illness’ and ‘treatment’ suggest that it perhaps finds itself aligned with medicine, therefore with the medical or biomedical model. The literature review highlighted for many authors including Cox (2010), Freeth (2007) and Loewenthal (2011) concern regarding psychotherapy within the medical model. A ‘model’ according to Engle (1977:130) is “...nothing more than a belief system utilized to explain natural phenomena, to make sense out of what is puzzling or disturbing”. This statement suggests that cultures have often come up with models to help explain and understand confusing and disturbing situations which could include illness and disease. Shah & Mountain (2007) express the view that there are many differing opinions on what is meant by the term ‘medical model’ and state “We believe that we need a simple definition of the medical model, which incorporates medicine’s fundamental ideals, to facilitate clarity and precision, without denying its shortcomings”. Laing (1971) wrote “The medical model is a term referring to the set of procedures that all doctors are trained to. The procedures comprise of complaint, history, examination, ancillary tests if necessary, diagnosis, treatment and prognosis”. The medical model was originally intended for physical health yet according to Bohart & Tallman (1999) research and the practice of psychotherapy has become, and continues to be, heavily influenced by the medical model. Many credit the work of Freud as bringing psychological and emotional aspects to find a place within the medical world. Elkins (2009:268) wrote:

“The new procedure, known as psychoanalysis, was a product of the medical community and everything associated with it was cast in medical terms. Hysteria, along with other psychological problems identified by Freud, was a ‘mental illness.’ A ‘doctor’ ‘diagnosed’ the ‘patient’ on the basis of ‘symptoms’ and administered ‘treatments’ designed to ‘cure’ the ‘illness.’ Thus, the medical model was applied to psychological problems and psychotherapeutic processes as it had been applied to physical illness and healing”.

Elkins continues to state “One of the first things we notice is that the typical psychotherapeutic experience, looked at objectively, has almost nothing to do with medicine”. He does acknowledge certain conditions which have genetic or psychochemical causes including Down’s syndrome and Alzheimer’s, however, Elkins posits the majority of experiences that are often classified as mental illness have no place being aligned with medicine, and how the medical model is intended to be seen as a metaphor:

“In these cases the medical model is the proper explanatory system but unfortunately, this makes it easier to extend the model (almost by sleight-of-hand) to other mental, emotional, and behavioral problems that are not illnesses in any literal sense of the term but are simply human experiences brought on by faulty learning, poor skills, stressful events, or other difficulties in the personal and interpersonal arenas of life. When we label such phenomena “mental illnesses,” we are speaking in analogical, not literal,

terms. Unfortunately, most clinicians fail to see that the medical model is only an analogical system and that what they call “mental illnesses” are only so in the analogical or metaphorical sense” (Elkins 2009:274).

Many other authors including Bettelheim (1984) and Whittaker (1992) also argue that the term ‘mental illness’ needs to be taken as an allegory. Bettelheim (1984:39) suggests that Freud’s work regarding mental illness needs to be taken as a metaphor and warns of the dangers if it is not:

“Of all the metaphors that Freud used, probably none had more far-reaching consequences than the metaphor of mental illness, and – derived – from it – the metaphor of psychoanalysis as the treatment and cure of mental illness. Freud evoked the image of illness and its treatment to enable us to comprehend how certain disturbances influence the psyche, what causes them, and how they may be dealt with. If this metaphor is not recognised as such but, rather, taken as referring to objective facts, we forfeit a real understanding of the unconscious and its workings”

Whittaker (1992:40) wrote “a narrow model has resulted in a pseudoscientific orientation in which ‘mental illness’ is treated almost entirely by somatic means instead as a metaphor”. Whittaker is implying that the dangers of not seeing ‘mental illness’ as a metaphor can result in treating physical conditions and never acknowledging the underlying psychological distress.

Elkins (2009) continues the discussion regarding mental illness as a metaphor highlighting further dangers including the fact it is not a clear analogy meaning that some see it as such, whereas others do not resulting in conflicting and confusing positions on the subject:

“Normally, analogies are intended to illumine and clarify but the medical model, as an analogy, obscures, confuses, and leads even clinicians to believe that certain problems of clients are literally “mental illnesses” when they are not. Thus, the medical model not only fails to describe what actually happens in therapy but it also creates confusion” (Elkins 2009:275).

If ‘mental illness’ can be, and perhaps often is, taken literally, instead of allegorically, it provides a possible rationale why psychotherapy finds itself often sitting within the medical model and with medical terminology. Words such as ‘patient’, ‘symptoms’, ‘treatment’ and ‘diagnosis’ demonstrate this, as it aligns psychotherapy with the vocabulary used within medicine. Other terms, which are even more prevalent in today’s culture and discourse, such as ‘evidence based practice’ lead psychotherapy to be aligned with science which, according to Elkin (2009:277), is “the most respected and powerful epistemological system in our culture” in turn placing psychotherapy within the medical model into an elevated position. Shah and Mountain (2007) express the view that psychotherapy is taught from a scientific and medical background and in order to maintain the elevated position psychotherapy continue to deny its shortcomings. Wood (2012: 171) backs up the fact that the medical model is often taught without looking at the possible

limitations and consequences in respect to both the psychotherapy and medical professions, claiming that “physician’s beliefs are moulded and shaped by their professional education which reinforces the biomedical model without introducing the perspective of scientific critique”. Engel (1977:130) also appears to agree with the point, however, goes further to suggest that beliefs regarding the medical model are formed prior to even commencing any training “In our culture the attitudes and belief systems of physicians are moulded by this [medical] model long before they embark on their professional training”. Engel’s words highlight the dangers of the cultural attitudes, suggesting that trainings often find themselves orientated towards the dominant discourse, and teach and train these views without encouraging critique and debate.

Whilst investigating the literature surrounding the training of counselling psychologists, the researcher found that the BPS (2012) provided guidance on professional training course requirements. These included: “An understanding of the diverse philosophical bases which underpin those psychological theories that are of particular relevance to counselling psychology” and “An understanding developed to postgraduate level of the philosophy, theory and practice of at least one specific model of psychological therapy”. The BPS does not elaborate or make it clear as to which psychological theories or which psychological therapy models are necessary or relevant to counselling psychology. The researcher is left to wonder whether this is then open to each individual training school to choose, which could lead to a different approach to counselling psychology dependant on where the student trained. The researcher chose to look further into the counselling psychology course at the university where he was studying and identified that one of the components

was entitled “Assessment, diagnosis and clinical presentations” (Roehampton.ac.uk 2015). The course module overview states:

“As many counselling psychologists will work in a multidisciplinary team, in particular within the NHS, they need to have an understanding and working knowledge of psychiatric diagnoses and classification systems, while being aware of the critiques” (Roehampton 2015).

This highlights the fact that this specific counselling psychology training programme aims to provide an understanding of psychiatric diagnosis and the use of classification systems. It also appears to prepare the students for the possibility of working in environments, such as the NHS, where the use of psychiatric diagnosis is prevalent and possibly set them up to adopt and accept a medical model approach. The statement above does, however, suggest that the training programme acknowledges the importance of teaching the critique to psychiatric diagnosis and classification systems. As there does not appear to be a set training programme for counselling psychology, as alluded to by the BPS (2012), the researcher is mindful that the course module stated above may not be included in different counselling psychology training programmes, however, wonders whether other courses also could be seen to prepare counselling psychologists to work within a medical model setting.

The above, highlights some of the reasons as to why psychotherapy has become part of the scientific and medical model. The literature has identified many authors including Boyle (2007), Davies (2013) and Tamimi & Radcliff (2005) expressing

concern with regard to the fact there is no evidence for the existence of specific psychiatric diagnoses, even though it is taught that there is. Wood (2012) provides insight into the possibility that psychiatry has evolved from a scientific and medical model into one that incorporates a traditional or folk model approach. Wood states the difference between a scientific and folk method is that “Unlike scientific models, which are revised or abandoned when they fail to account for all of the data, folk models become dogma and discrepant data are forced to fit the model or are disregarded” (Wood 2012: 170).

The fact that psychotherapy has found itself often placed within the medical model provides a possible rationale as to the reasons many psychotherapists, upon completion of their training, find themselves working within medical settings, such as GP surgeries, hospitals and national health service clinics. The length of time that psychotherapy has been placed within the medical model and the work places of psychotherapists within medical settings have led many to not be able to see any alternatives to the medical, scientific way of thinking about human distress. Once inside the medical model, the language used by psychotherapists, as mentioned previously, can easily start to incorporate medical terminology in order to back up any claims made. Boyle (2006) suggests that the use of medical terminology to back up claims to alleviate human distress leads to significant support then coming from other areas including the pharmaceutical industry causing there to be “great difficulty of persuading people to listen to, understand and accept alternatives” (Boyle 2006: 191). Dudley (2004:14) wrote about how she struggles not to use diagnostic terminology in her work as a therapist, but fails to do so every day. She provides a rationale for this stating she is aware of her desire to fit in with the “main

influential groups and to experience the power and connection that such belonging gives”. These points raise the question as to the benefits and limitations of psychotherapy being conducted within a medical setting. It also reinforces Boyle’s position regarding the difficulty in people recognising there are alternatives to the medical model.

Boyle (2006) provides an alternative to the medical model believing one of the most important components is the need to remove genetics and biology from the privileged position that society currently has them placed, and to put specific emphasis on “the important of interpersonal and social factors in causing emotional distress and disturbing behaviour” (Boyle 2006: 192). Boyle also writes about the importance of the meaning of client’s experiences in relation to their lives, familial and social contexts. The alternative, outlined by Boyle, is also backed up by Sanders (2007:114) stating “An equally plausible alternative to a medical explanation for distress is that the symptoms of so called mental illness are understandable responses to a noxious environment. The way that we structure our social and economic relations affects our biology and psychology”. This alternative is highlighting the position that reductionist biological models do a disservice to human distress as it does not take into account factors that cannot be identified and treated through aspects such as “neuroimaging, genetics and medication” Sanders (2007: 115).

Another alternative to the medical model is to adopt the approach that the work done within psychotherapy is a co-created dialogue between the client and psychotherapist. Bohart & House (2008: 195 – 196) write “In contrast to the idea

that the therapist is ‘treating’ a ‘disorder’, therapy becomes a co-created dialogue between two (or more) intelligent, living, embodied beings. The guiding metaphor for this approach is therefore conversation and dialogue”. This alternative places emphasis on the therapeutic relationship and what is co created during psychotherapy, rather than focusing on symptomatic relief in respect to the original presenting ‘issue’.

The fact that psychotherapy has become intertwined with the medical model has also provided confusion as to the reasons for someone to enter into therapy. The medical model often aims to identify a problem in order to administer treatment with the goal of fixing the problem. Bellah *et al* (1995) wrote about the humanistic movement in America in the 1960s and the great numbers of people who were involved in some form of psychotherapeutic group or activities not for the purpose of treating any problem or ‘illness’. Elkins (2009: 271) picks this up this point stating that:

“The vast majority of those who took part in these activities did not see themselves as participating in ‘treatments for mental illness.’ Indeed, it’s likely that this idea seldom, if ever, crossed their minds. The focus of the human potential movement and the “therapeutic culture” of the 1960s was not on curing mental illness but on personal growth, self-awareness, improved relationships, and more effective interpersonal skills”.

Elkins (2009: 272) continues to write that “the model cannot account for the fact that the vast majority of clients who seek psychotherapy do so for reasons other than mental illness”. Therefore another alternative is to remind oneself of the fact that just like in the 1960’s psychologically-orientated groups and therapeutic activities that psychotherapists work within are more about personal development, self awareness and improved relationships rather than on alleviating symptoms of a ‘mental illness’.

Another non-medical view on psychotherapy is provided by Wampold *et al* (2001:268), which is acknowledged to have been heavily influenced by the work of Frank and Frank (1991). This alternative to the medical model consists of four elements:

“The first component is an emotionally charged, confiding relationship with a helping person (i.e., the therapist) in which the client expects the relationship to develop as he or she divulges emotional and psychologically sensitive material. The second component is a therapy process that transpires in a healing context; the client believes that the therapist will provide help and will work in the client's best interest. The third component stipulates that there exists a rationale, conceptual scheme, or myth that provides a plausible explanation for the client's symptoms and is consistent with the client's worldview. The final component of the contextual model involves a procedure or ritual that is consistent with the rationale of the treatment and requires the active participation of both client and therapist”.

Wampold *et al* (2001: 270) continues to state that even though there are alternatives to the medical model as mentioned above which consist of specific components, psychotherapy is not about simply applying techniques. “The alternative to the

medical model is not a collection of common independent factors, such as the working alliance, expectation of progress, and therapist empathy. Every therapy should have a rationale, be administered in a healing context, and contain therapeutic actions consistent with the treatment rationale.” Wampold *et al* also show how the therapist may adopt specific ways of working with the patient “depending on their own predilections and training and the client's worldview, attitudes, and values”.

The alternatives highlighted above suggest there are other ways of thinking about psychotherapy and that the medical model approach is not the only option. The researcher believes that the alternatives appear to take a far more phenomenological approach to human distress.

2.8 Previous research

The researcher was able to locate only one research study which explored whether the presence of a psychiatric diagnosis influenced clinicians. The study was a quantitative one and looked at whether the presence of a psychiatric diagnosis influenced educational psychologists’ decision for children with emotional disturbance to be eligible for specialist education. The findings of the study revealed that those most likely to be considered eligible for specialist education were those who already had been given a psychiatric diagnosis. The presence of the psychiatric diagnosis was more of an influencing factor than whether the child met eligibility criteria or not. The findings concluded by stating “Somewhat unexpected, however,

were the results suggesting that the presence of a psychiatric diagnosis in referral information when the child does not meet federal eligibility criteria resulted in an almost identically strong ED recommendation as when the child meets the criteria but has no diagnosis” (Douglas, Toffalo and Pedersen, 2005). This suggests that school psychologists could inappropriately view externally provided psychiatric diagnosis as an acceptable substitute for other eligibility data required by special education law, or at least, as an indicator of external affirmation or concurrent validity. This study highlighted how the presence of a psychiatric diagnosis did influence the way in which the participants conducted their work. This study indicates that psychiatric diagnosis can enable access to specific services. Therefore, those who do not have a psychiatric diagnosis may not have access to these services. It also demonstrates that clinicians perhaps concentrate more so on a diagnosis which has been made in the past rather than focusing on what is occurring for the child at that specific moment. The researcher questions whether this influence could be present for psychotherapists and counselling psychologists working with clients.

2.9 Conclusion of the literature review

Upon completing the literature review, the researcher identified a number of differing views surrounding psychiatric diagnosis. There appeared to be more written regarding the negative connotations associated, and dangers regarding its use. However, the literature shows that its use is on the increase. The researcher also posits that the majority of people cited who express a view towards being pro or against diagnosis were also able to identify with many of the arguments for the other

side of the argument, however, even though many are able to discuss both sides of the argument, the researcher feels that they are either for or against its use.

The literature highlights how the use of psychiatric diagnosis can produce significant implications including taking away from human experience, which also appears to have its own pros and cons, and how a diagnosis can produce some of the effects associated with labelling theory. The literature also draws attention to the fact the use of psychiatric diagnosis can be abused in different respects. These include the possibility of abuse for political motivations, individual needs and monetary gain.

The literature review identified only one piece that highlighted the ways in which it can affect a clinician's method of working, however did not explore the clinicians lived experiences of this.

For the researcher, it demonstrates how it is extremely important for a clinician to be aware of their own feelings in relation to the use of psychiatric diagnosis as it contains important responsibility for the clients they are attempting to help.

3. METHODOLOGY

The chapter explores the epistemological, ontological and methodological issues that arise from the question being investigated; “In what ways, if any, does psychiatric diagnosis influence the way psychotherapists and counselling psychologists work?”

The issues addressed within this chapter aim to demonstrate the rationale for choosing Interpretative Phenomenological Analysis as the research method.

Finally, this chapter explores the role of comparisons in relation to this study and whether there is a rationale for attempting to use IPA as a comparison tool to illuminate the findings between the two groups further.

3.1 Considerations

The literature review has highlighted a number of authors expressing their views surrounding the subject of psychiatric diagnosis within psychotherapy. The researcher found little evidence of the actual experiences of practitioners in relation to the way that psychiatric diagnosis does or does not influence the way clinicians practice. Therefore, the body of knowledge surrounding the subject could be greatly enriched by specific qualitative knowledge aiming to explore, describe and interpret the lived experiences of the individuals who work in the field of psychotherapy.

In order to consider which method to use to complete this study, the researcher reflected upon what the research question is aiming to illuminate. The conclusion from this reflection is that the question is intended to try to explore psychotherapists’ and counselling psychologists’ lived experiences regarding psychiatric diagnosis and

how, if at all, it influences the way in which they work with clients. An important element of the research question, which was fundamental in influencing the choice of research method, was the fact that the researcher believed it could be difficult to reach a single conclusion or hypothesis. One of the reasons the researcher felt this would be difficult was that, as the researcher, he would be trying to make sense of what the participant was trying to make sense of. The dominant discourse within mental health, highlighted within the literature review (Dudley 2004, Loewenthal 2007), may contribute to the participants finding it difficult to articulate their views and possibly not wanting to disclose their true feelings because of a fear of being seen to speak out against the prominent discourse. In addition, participants may attempt to make sense of their feelings and thoughts with the researcher attempting to make sense of what is being spoken. Therefore, the researcher felt that any conclusions or findings from this study would not provide any universal hypothesis regarding the subject.

Understanding the above was crucial in the decision making process when contemplating which research method the researcher felt would be most suitable for the study. Looking at the differences between qualitative and quantitative methods was the next step in helping to identify the right method. “Quantitative methods are not intended to take healthcare professionals (HCPs) to the heart of the patient’s lived experience: they rightly focus on matters such as treatment outcomes, survival rates and clinical governance” (Biggerstaff, 2008: 217). “Qualitative studies typically adopt an idiographic approach which emphasises the uniqueness of phenomena rather than seeking to make nomothetic (broad universal) generalizations” (Dallos, 2005: 41). For the reasons already discussed, the researcher

felt there was no specific hypothesis he wanted to test. Also, the study is interested in the individual participants and is not interested in making broad generalizations. Therefore, a qualitative method was selected as opposed to quantitative. Another reason that helped shape this decision was that the only research found on this subject matter was a quantitative study (Douglas, Toffalo and Pedersen 2005) as outlined in the literature review. This study came to a conclusion that the presence of a psychiatric diagnosis did influence the decision making process of psychologists looking at eligibility for specialist education. The study was not concerned with the lived experiences of the participants, therefore a qualitative study may help to illuminate potential reasons for the findings within the study. A quantitative study such as the one mentioned, may hypothesise about all these questions raised. The researcher is not trying to criticise the usage of generalizations and hypothesis, merely to point out it is important to be aware that generalisations can be misinterpreted or incorrect as iterated by Dallos (2005). Dallos also informs us that making generalisations, could be argued, is an activity that human beings fundamentally do, for us to be able to place our experiences into categories to help make more sense of the world. Cayne (2014), however, shows how generalisations perhaps are used in order to alleviate anxiety “Another problem with the need to locate ourselves in an origin is that that it takes us to the reassurance of what we already know which gets in the way of learning something new”. This may also be said in relation to psychiatric diagnosis. It could be argued that psychiatric diagnosis is used to offer reassurance and reduce anxiety, however, it may get in the way of learning something about the patient. Heidegger (1977) may see these categorisations and generalisations as stripping something fundamental from a person’s being.

Therefore, by exploring the experiences of the participants and not aiming to make a generalisation for all counselling psychologists and psychotherapists, we may be better placed to illuminate why psychiatric diagnosis can influence the way in which they work . Willig (2001:11) writes:

“Qualitative research can produce descriptions or explanations. It can aim to ‘give voice’ to those whose accounts tend to be marginalized or discounted. It can aim to interpret what people have said in order to explain why they have said it”

The researcher believes these descriptions are important to provide an understanding of the way the clinicians in question are, or are not, influenced by psychiatric diagnosis.

The next aspect of the researcher’s exploration of an appropriate method was to identify a qualitative method that helped illuminate the phenomena in question. An empirical phenomenological method was first considered. The word phenomenology comes from the Greek language where *phainómenon* means ‘that which appears’ and *lógos* which means “study”. According to many, including Priest (2000), Husserl is seen as the person who led the phenomenological movement in the twentieth century. For Husserl, personal experience is the first order knowledge system, and science had to take a position behind the personal experience. He was unhappy with the way psychology was positioning itself as a natural science rather than as a phenomenological one. He wanted to find a way that someone might come to know

their own experience of a specific phenomenon and by doing so, one might be able to uncover the essential qualities that make up that experience, and wanted phenomenologists to go ‘back to the things themselves’ (Husserl as cited in Smith *et al* 2009). The ‘thing’ in question is the experiential content of consciousness and he is talking about the many different obstacles that often get in the way of its pursuit. Therefore, for Husserl, phenomenology meant being able to step outside of the day-to-day life we live so one can examine the every-day experience. “Adopting a phenomenological attitude involves and requires a reflexive move, as we turn our gaze from, for example, objects in the world, and direct it inward, towards our perception of those objects” (Smith *et al*, 2009:12). The way in which Husserl invited us to do this was called epoché. According to Moustakas (1994:85) “Husserl called the freedom from suppositions the epoché, a Greek word meaning to stay away from or abstain”. Finlay (2009:7) writes that “Giorgi (1997) more straightforwardly, argues that the phenomenological method encompasses three interlocking steps: (1) phenomenological reduction, (2) description, and (3) search for essences”. At first, this method seemed to feel appropriate for this study until the researcher tried to gain a better understanding of what Giorgi had written. The first problem, the researcher believed, was the bracketing that reduction requires. It is not simply the acknowledgment of the researcher’s bias instead, it is where “one simply refrains from positing altogether; one looks at the data with the attitude of relative openness” (Giorgi 1997 as cited in Finlay 2009:12). Finlay also goes on to provide a more in depth quote regarding bracketing:

“More specifically, (Ashworth, 1996) suggests that at least three particular areas of presupposition need to be set aside:(1) scientific

theories, knowledge and explanation; (2) truth or falsity of claims being made by the participant; and (3) personal views and experiences of the researcher which would cloud descriptions of the phenomenon itself”.

(Giorgi 1997 as cited in Finlay 2009:12)

This reduction did not feel totally possible for the researcher with regard to the question in hand for a number of reasons; the most fundamental was that the large majority of the researcher’s work, within mental health, had been working in psychiatrist led services, which is thoroughly entrenched in the medical model. The researcher felt that his research may well be influenced by this, and therefore, bracketing out many of the medical model elements from his work would be impossible.

Another reason why an empirical phenomenological method was not selected was regarding the notion of essences. The researcher believed that it would be impossible to find the essence of participant’s experiences surrounding the research question. Sartre writes “existence comes before essence” (Sartre 1948 in Graham 2004). This suggests human beings are not something that can be discovered but, instead, are always becoming ourselves and are an ever evolving project. This, along with Heidegger’s (1962) *Being and Time* help the researcher to ground his work in the concept of where it is in the particular time and place in the world. Being is always in time and always in flux. Therefore, a psychiatric diagnosis is a snapshot in time and may not be the same in any other moment. The same is true for this study, the possible outcomes could mean something different later on in time and in relation to

different cultures. Also, asking the same question to the same participants at any other moment in time would lead to different findings.

Due to the fact mentioned above, the researcher was concerned that bracketing out his own thoughts and personal views may be difficult to undertake, and also acknowledges that there may be further bias, for example ones that he is not consciously aware of. Thus, the researcher believed that if he would find it impossible to bracket out his own bias, then a heuristic inquiry may serve as a valid method for this study, as a heuristic inquiry would allow the researcher to be at the centre of the project. Moustakas (in Hiles 2008:42) wrote “in every learner, in every person, there are creative sources of energy and meaning that are often tacit, hidden, or denied”. The concept of tacit knowledge originates from Polanyi where he states “we can know more than we can tell” (Polanyi, 1966:4). Therefore, Moustakas implies that a heuristic inquiry could illuminate knowledge in relation to the research question that is already within the researcher. The phases of engagement, immersion, incubation and illumination seemed to fit well with many of the aspects of the researcher’s life in respect to understanding, and so could be utilised for this project. The researcher questioned whether this approach could become more confusing for the researcher and the reader, as Sela-Smith (2002) points out, that throughout the study, the study could gradually move from a consideration of the researcher’s experience into a more generalised experience. The researcher wondered whether, just as he believed it to be impossible to bracket out his bias, it perhaps could be impossible for him to not do as Sela-Smith mentioned, and move the study towards a more generalised theme, especially in relation to the fact Dallos (2005) had expressed, mentioned above, that human beings often make generalisations.

Another rationale for not selecting a heuristic inquiry as the method, was that the study is interested in differing groups' views and experiences in relation to how psychiatric diagnosis influences the way they work. The researcher would only represent one of the groups being investigated. Even though there appears to be issues for this study surrounding the use of bracketing, there also appeared to be issues in relation to the opposite, being personally immersed in the study. Both may close down possibilities from emerging. For these reasons a heuristic inquiry was not chosen.

As identifying bracketing and immersing oneself in the study could be problematic the researcher questioned if there could be a balance between the two. McLeod (2003) states that phenomenological research is largely hermeneutic in nature, this led the researcher to be drawn to the writings of one of Husserl's students, Heidegger. "He [Heidegger] questioned the possibility of any knowledge outside of an interpretative stance, whilst grounding this stance in the lived world – the world of things, people, relationships and language" (Smith *et al* 2009:16). This sat comfortably with the researcher for this particular study as it felt possible the participants themselves may not be completely clear to what extent, if at all, the presence of an externally provided psychiatric diagnosis impacts and influences the way in which they work. Therefore, they may struggle to articulate this in interview, meaning the researcher may need to make some interpretations during the process, as well as in the analysis of the data collected.

Looking at the reasons for a researcher deciding upon a method that incorporates an interpretative analysis Dallos (2005:53) writes:

“The researcher wants to understand and represent the participant’s point of view, perhaps adopting a critical realist position in relation to knowledge. The researcher assumes that the participant’s point of view, in terms of constructs and assumptions, is relatively stable over time. The researcher wants to extract major themes and issues in participant’s accounts. The researcher wants to develop hypotheses and small scale theories that connect the themes”

Dallos (2005:53) goes on to write “There are two main types of interpretative theme analysis: grounded theory and interpretative phenomenological analysis (IPA).” These two methods will now be considered.

Grounded theory, at first glance, seemed to fit the purpose of the method for this research study. It is a qualitative approach that incorporates the interpretative nature of phenomenology however, there were specific aspects of grounded theory that helped inform the decision to not utilise this approach. The first reason was that one of the aspects of grounded theory is to continue sampling until theoretical saturation is achieved. This felt it was looking too inflexibly for an ultimate theory behind the phenomena. This study is not intending to discover a theory, as it is concerned with a more descriptive and local theory, as opposed to the formal theories that can be generalized to a broader population. Another reason for rejecting this method for the study is that “The researcher wants to delay the literature review until their own hypothesis begin to develop” (Dallos, 2005). The researcher acknowledges that grounded theory does not dictate that a literature review must be completed prior to

the data analysis; however, the researcher believed that if the literature review was not conducted until after the interviews and analysis then the literature review would be more influenced by the findings rather than his own experiences and bias prior to commencing interviewing others. The researcher felt that his own motivations for choosing this study and the way in which it may or may not influence the whole study, including the literature review, were of significant importance and, possibly more so, than how the study had been shaped by the analysis of the participants data.

The researcher was then drawn to considering Interpretative Phenomenological Analysis (IPA). According to Smith *et al* (2009:11) IPA “is an approach to qualitative, experiential and psychological research which has been informed by concepts and debates from three key areas of the philosophy: phenomenology, hermeneutics and ideography”. The researcher had identified that he desired this psychological research study to be a qualitative one based upon the participants’ experiences. Therefore, he chose to investigate whether the philosophical aspects of phenomenology, hermeneutics and ideography would also fit with the aims of the study. A pure phenomenological method had previously been rejected, however, many of the theoretical underpinnings seemed to fit with the study.

Phenomenological research strives to “construct a possible interpretation of the nature of a certain human experience” (Van Manen 1990: 41). IPA attempts to “give voice” to the specific phenomena and then endeavours to make sense of the original description in regards to wider contexts within society and culture. (Larkin *et al* 2006: 106). The idiographic aspect of IPA is concerned with how participants explore a particular phenomenon within a specific context, therefore not aiming to

make overall generalisations. “Hermeneutics is the theory of interpretation” (Smith *et al* 2009:21). The researcher was drawn to incorporating hermeneutics within the study in order to attempt to possibly illuminate not only what is spoken or on the surface, but also what may be hidden or disguised. IPA acknowledges the differing views on phenomenology and takes on board ideas based upon the Husserlian views as well as incorporating Heidegger and Sartre’s work which has already been mentioned. IPA also acknowledges important contributions from Merleau-Ponty. This supports the double hermeneutic aspect of the study in that stories which emerge from interviews will never have the same meaning to the interviewer as they do to the interviewee “I perceive the other as a piece of behaviour, for example, I perceive the grief or the anger of the other in his conduct, in his face or his hands, without recourse to any ‘inner’ experience of suffering or anger... But then, the behaviour of another, and even his words, are not that other. The grief and the anger of another have never quite the same significance for him as they have for me. For him these situations are lived through, for me they are displayed” (Merleau-Ponty, 1962). The participants involved with the study will be attempting to make sense of the way in which psychiatric diagnosis influences their work and try to articulate that. The researcher is then engaged in a double hermeneutic, as one will be attempting to interpret what is being told by the participant. “The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world” (Smith *et al*, 2009). IPA is not only interested in the similarities which may emerge during the study, but also the differences and diversities, IPA is “committed to how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context” (Smith *et al*, 2009).

The researcher believes this study was concerned with phenomenology, hermeneutics and ideography, therefore came to the conclusion that IPA was the most appropriate method to use in order to illuminate the question in this study. IPA would be used for the method in order to provide two sets of findings. One set of findings for the psychotherapists and one for the counselling psychologists.

Arriving at the conclusion to use IPA as the method for conducting the two studies the researcher identified that by selecting two groups to research could imply there would be an element of comparison between the groups within the study. The focus of the study was not to specifically compare the two groups; however, as some aspect of comparison was emerging, the researcher decided to explore whether the findings from the two IPA studies could be used as the develop a comparative tool. The researcher identified two IPA studies; Mitchie *et al* (2004) and Mitchie *et al* (2003) which provide an element of comparison between two groups. Upon exploration of these studies, there did not appear to be any set procedure as to how to conduct a comparison. There also did not appear to be any discussion as to the strengths and limitations of adopting a comparative stance within the studies. Therefore, the researcher chose to explore what is meant by comparison, with the view that a potential method may emerge, to conduct this method, and finally to question the strengths and limitations.

According to Boeije (2002) there are many issues surrounding comparisons within qualitative research, including the reason for the comparison, the subject of the comparison, and the phase of the research in which it took place. Boeije posits that

these issues and the lack of clarification often reduce the credibility of qualitative studies. Therefore, qualitative studies that, in themselves, aim to make comparisons are likely to be open to criticism. This could mean that any comparison between two already completed qualitative studies could be open to further criticism based upon the same argument. The researcher, aware of the potential limitations, chose to look at what is meant by comparison study. Kazdin (2010) wrote how comparison studies are a specific research methodology which has the aims of comparing two or more independent variables on dependent measures. Attempting to break this meaning down further Shabani & Lam (2013:160) write:

“In general, there are four common subtypes of comparison study: (1) studies that directly manipulate and compare the effectiveness, efficiency, preference, and/or acceptability of different independent variables; (2) studies that compare different independent variables without direct experimental manipulations (e.g., LeBlanc, Esch, Sidener, & Firth, 2006); (3) studies that compare behavioral, psychological, physiological, or biological characteristics of individuals with different diagnoses (e.g., Kern et al., 2008; Lacroix, Guidetti, Roge, & Reilly, 2009); and (4) studies that compare the similarities and differences of the conclusions obtained in alternative assessment methodologies (e.g., Hall, 2005; Thompson & Iwata, 2007)”.

The first subtype that Shabani & Lam wrote above did not seem to fit with a phenomenological study such as this one, as it appears to be concerned with controlling variables, and human experience, in phenomenological terms cannot be

reduced to variables. Therefore this subtype may be seen in a more positivistic and quantitative area of research. The second subtype is concerned with comparing variables, therefore, could also be seen as moving away from phenomenology; due to the non-manipulation of the variables which suggests this may be more in line with randomised controlled trials, once more in line with a quantitative approach. The third subtype aims to compare different characteristics of participants based upon specific diagnoses. This could be seen as more statistical than phenomenological, based on possibly part of a positivistic paradigm. However, this seemed closer to what this study is exploring, as an argument could be made that this is in a qualitative realm. The fourth subtype compares similarities and differences. Shabani & Lam appear to be suggesting comparing different methodologies in order to obtain the similarities and differences and the researcher believes that this principle could be adapted to looking at the similarities and differences obtained via the same method. Smith & Osborne (2008) state how similarities and differences are an important aspect of IPA therefore led the researcher to viewing this subsection as viable foundation for the comparison. Shabani & Lam do not state how to conduct the fourth subtype, therefore the researcher needed to identify his own method based on the principle of identifying the similarities and differences between the findings from the two IPA studies.

The method for conducting the IPA studies is now explored, followed by the researcher's own method for identifying and discussing the similarities and differences between the two sets of IPA findings.

3.2 Method for Interpretative Phenomenological Analysis (IPA)

Smith *et al* (2009) sets out a method for conducting IPA and acknowledge that the method does not need to be fixed and can be adapted. The structure that has been adopted for this study is discussed below:

3.2.1 Selecting participants

The researcher identified that the question was of importance to his way of working as a psychotherapist. Smith *et al* (2009) posit that IPA researchers should attempt to find a sample to whom the research question will be meaningful, this led to the researcher selecting psychotherapists as the sample group for the first part of this study. Below are the inclusion criteria for the psychotherapists:

- Professional Membership

Each participant must be a current member of either the UK Council for Psychotherapy (UKCP) or an accredited member of the British Association of Counselling & Psychotherapy (BACP). This is to ensure that each psychotherapist who is interviewed has had a level of training and practice that meets a standard which is deemed as acceptable to one of the two largest bodies of psychotherapists in the UK.

- Type of Clinical Practice

Participants must be currently working as a psychotherapist in private practice either in a full or part time capacity. This could also be alongside an NHS position. This criterion is to ensure that the participants are all currently working in their profession and all have experience within the private sector.

- Supervision

Each participant must be in regular supervision of at least one hour every two weeks. This ensures that each participant is not working totally independently. This also enables every participant to have a therapeutic place to be able to take any concerns or personal issues which may arise subsequent to the interview.

Excluded from the study are psychotherapists who work solely in the National Health Service (NHS). The reason this was included in the exclusion criteria was one of time constraints. In order to interview these participants the researcher would have had to obtain ethical approval from the NHS, this study is being completed in a short time period and such ethical approval would have taken longer than the study allowed.

Upon completion of the first part of the study, the researcher questioned whether the findings were specific to psychotherapists or whether other groups within the psychological therapies community held similar views. One of the suggestions for further studies, from the first part of this study, was to ask the same question to psychiatrists and / or psychologists. The rationale for selecting the second sample group to consist of counselling psychologists is set out below:

A paper published by the Royal College of Psychiatry entitled “Role of the Consultant Psychiatrist” states:

“All consultant psychiatrists should first be good doctors... The central role that integrates all of the CanMEDS roles: applying medical knowledge, clinical skills and professional attitudes in the provision of patient-centred care” (Royal College of Psychiatry 2010)

This paper highlights that psychiatrists are, at their core, doctors and apply medical knowledge within their role. To the researcher, this appeared largely removed from the role of the psychotherapist and possibly at odds with it. Psychiatric diagnosis is also part of a psychiatrists’ training and this study is concerned with the way in which psychiatric diagnosis impacts professionals’ work, when they have not had specific training in the subject. Therefore, the researcher looked at the possibility of comparing the psychotherapist’s data with data obtained from psychologists, and needed to decide whether the inclusion criteria for psychologists should be broken down further, so looked at which division within psychology fitted most closely with the role of psychotherapists. The divisions within the British Psychological Society consist of:

- Academia, teaching & research
- Clinical
- Counselling
- Educational
- Forensic

- Health
- Neuropsychology
- Occupational
- Sports & exercise
- Scottish division of education

The researcher identified that for the overarching sample group to be as homogenous as possible, the participants needed to be seeing clients specifically for psychotherapy, therefore this excluded all except for clinical, counselling, health and neuropsychology. Neuropsychology was then dismissed as it is concerned with brain function as well as human behaviour and emotions. Health psychology was also ruled out due to the fact the division is concerned with physical health related matters as opposed to general psychotherapy. This left counselling and clinical psychology to choose from. In order to try and have a total sample group that was as closely similar as possible, within the restrictions of selecting two different professions, the researcher decided upon only interviewing counselling psychologists. The reason for excluding the clinical psychologist division was that counselling psychology is possibly more closely related to psychotherapy. According to the British Psychological Society (BPS) in their Psychology Practice Guidelines (2006) counselling psychology has “a value base grounded in the primacy of the counselling or psychotherapeutic relationship”. The BPS does not make as clear a statement about where clinical psychology has its value base grounded, however, in their Practice Guidelines – Division of Clinical Psychology (1995) states that “Clinical psychologists are committed to providing clinical services that are seen to positively value our clients, and which treat them with

respect and dignity”. This statement implies that clinical psychology places more emphasis on positivity than hermeneutics, and clinical services, rather than the therapeutic relationship and phenomenology. This also implies that it fits more closely into the medical model than counselling psychology.

In order to ensure an overarching homogeneous sample group a similar inclusion criterion was drawn up for the recruitment of counselling psychologists.

- Professional Membership

Each participant must be a current chartered member of the British Psychological Society (BPS) and be registered with them as a counselling psychologist. This is to ensure that each counselling psychologist who is interviewed has had a level of training and practice and meets a standard which is deemed as acceptable to the largest regulatory body of psychologists in the UK.

- Type of Clinical Practice

Participants must be currently working as a counselling psychologist in private practice either in a full or part time capacity. This could also be alongside an NHS position. This criteria is to ensure that the participants are all currently working in their profession and all have experience within the private sector.

- Supervision

Each participant must be in regular supervision of at least one hour every two weeks. This ensures that each participant is not working totally independently. This also enables that every participant to have a therapeutic place to be able to take any concerns or personal issues which may arise subsequent to the interview.

- Gender

All psychotherapists interviewed were female, this was not an aspect of the inclusion criteria for the psychotherapist, however emerged naturally. This led the researcher to wonder whether it would be beneficial for the counselling psychologist participants to also be female. In order for there to be an overarching level of homogeneity within the two groups there is the argument that selecting only female participants for the study perhaps would be appropriate. Heffron & Rodriquez (2011) writing on the subject of comparisons stated “Smith *et al.* (2009) encourage a less ambitious project for beginners, focusing on perhaps comparing one dimension in a single group”. The researcher was wanting to not only look at one group, however believed that comparing one dimension, in this case, profession, would be advantageous to the ability of being able to actually complete a comparison study. Therefore, for this reason the researcher chose to attempt to keep the two groups as similar as possible with the exception of profession. This led the researcher to select gender as one of the inclusion criterion.

Excluded from the study are counselling psychologists who work solely in the National Health Service (NHS). The reason this was included in the exclusion criteria was one of time constraints. In order to interview these participants the researcher would have had to obtain ethical approval from the NHS, this study is being completed in a short time period and such ethical approval would have taken longer than the study allowed.

3.2.2 Recruitment of participants

Potential participants were identified and targeted either by email or by telephone and invited to take part in the research study. One private psychiatric hospital organisation was contacted and they agreed to circulate information regarding the research study to psychotherapists who are connected to the organisation. Interested potential participants were asked to contact the researcher directly for more information.

Before each interview the researcher sent out a consent form (appendix 1) to all who met the inclusion criteria and requested these be completed prior to the interview.

Sample

- Psychotherapists

All psychotherapists who participated were members of UKCP or accredited members of BACP. In total there were four participants all of whom work in private practice. One participant, in addition to working in private practice, also worked within a private psychiatric hospital. There was one participant who was a psychoanalytical psychotherapist, one who was a person centred counsellor, one psychodynamic psychotherapist and one integrative psychotherapist. All four participants were female.

- **Counselling Psychologists**

All counselling psychologists were chartered counselling psychologists registered with the Health and Care Professions Council (HCPC). Two of whom work within the NHS as well as in private practice, one works for a private mental health organisation as well as a private practice, and one is in full time private practice. All four participants were female.

3.2.3 Consent

Participants who agreed to take part in the study and who met the inclusion criteria were sent a letter to introduce the study which included the purpose of the research, confidentiality and the right to withdraw from the study (see appendix 1).

Before the commencement of the interview the participants were given an opportunity to ask any questions regarding the study. Each participant signed a written consent form.

3.2.4 Potential Distress

The researcher does not anticipate any potential distress to be raised due to the study, however, by reflecting upon one's own experiences there is always a risk of potential distress being raised. In order to minimise any potential issues, all participants were required to be in regular supervision in order that there was a space available to raise any issues after the interview. The researcher verbally informed each participant that they could stop the interview at any time and if they did not want to answer any specific questions they did not have to do so. The researcher also made available a de-brief session one week after the interview for each participant should they feel the need for this. A de-brief document was given to all participants upon completion of the interview (see appendix 2).

3.2.5 Confidentiality

Participants were informed that all information collated during the research study would be treated with the strictest of confidentiality. This was conveyed verbally before the interview and also within the consent form.

Participants were informed that all personal information that could identify them would be removed from the written transcripts. As a number of participants work within a hospital setting they were also informed that information would not be shared with the organisations for whom they work.

Pseudonyms were used for each participant within the transcripts and the study.

Consent forms were kept separately from the other material used within the study in order to ensure confidentiality.

All data were securely and confidentially kept in a locked cupboard within the researcher's home.

3.2.6 Ethical approval

The research for this project was submitted for ethics consideration under the reference PSYC 13/101 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 13.01.14.

(see appendix 3).

3.2.7 Data Collection

Smith *et al* (2009) recommends using semi-structured interviews for a research study using IPA and these were used throughout the study to collect data. This enabled an informal conversation to emerge and allowed the researcher the ability to be able to explore specific areas that may arise. A semi structured interview schedule was devised by the researcher (see appendix 4). One main question was asked with further questions to help facilitate the interviewee in the telling of their story, based upon their lived experiences. Some participants answered the questions without being asked. The interview questions were asked in an open ended manner in an

attempt to get as close as possible to the interviewee's story with as little influence from the interviewer as possible.

Due to the fact that one of the participants worked within a private organisation each participant was offered the choice to be interviewed at their place of work or at the researcher's place of work, which is a consulting room within a GP surgery.

Interviews ranged from thirty to sixty minutes in duration and were recorded using two separate audio devices in an attempt to avoid any loss of data due to equipment failure. As well as collecting the data from interviews, the researcher also kept a research journal where his own experiences and feelings were noted during the interviews as well as throughout the whole process of the research study.

3.2.8 Data Analysis

The transcripts and data were grouped into two, one for the psychotherapists and one for the counselling psychologists. These two groups were analysed separately.

The researcher transcribed each of the audio tapes and any references to specific names, except literary authors, and places of work were removed. The data collected was analysed using IPA as outlined by Smith *et al* (2009):

- *Engagement with the data*

Each transcript was analysed individually as to be in line with IPA's idiographic commitment. This involved listening to the audio recordings while reading the transcripts. This was followed on by reading the transcripts a number of times to allow the researcher to become immersed in the data.

Transcripts were re-read in an attempt to become further immersed in the data and to further explore their lived experiences.

- *Initial Noting*

This stage of the data analysis examined the semantic content and language use on an exploratory level. During this stage, the researcher noted anything of interest. Commenting was based upon three categories; descriptive, linguistic and conceptual. The descriptive comments were often about taking things at face value. These comments helped to summarise the interview and highlighted the objects that help to structure the experiences of the participant. Linguistic commenting explored the language used within the interview and could include the use of pronoun use, pauses, laughter and repetition. The conceptual commenting was more interpretative than the previous methods of commenting. This helped to move away from the explicit to the implicit claims of the participant and aims to move towards the participant's overarching meanings and understandings of the subject they were discussing.

- *Developing emergent themes*

Utilising the notes obtained from the previous stage the next stage was to develop emerging themes. This stage involved a shift away from the transcript primarily to the notes obtained in the previous stage; however, the notes were closely related to the original transcript. A two margined approach was utilised, the right hand margin was used for the exploratory comments and initial noting. The left hand margin was used to note the emerging

themes (appendix 5). This process aimed to produce statements that encapsulated the core of the participant's experience. Relationships and patterns were identified from the data and in addition the researcher's own interpretations were utilised. Each of the notes were typed up in chronological order (appendix 6)

- *Identifying connections across emergent themes*

The emergent themes were typed up and the researcher moved them around in order that they formed clusters of themes that were related to one another (appendix 7). From this a table was constructed which identified superordinate and sub themes, and was linked to the correlating text from the original transcripts to ensure the clusters did not take away from what is being said in the data.

- *Moving to the next case*

The above processes were then repeated for each of the participants within the group. Smith *et al* (2009) states that in order to adhere to IPA's idiographic commitment the researcher needs to attempt to bracket the ideas that emerged from the analysis of the previous cases whilst working on the next ones.

- *Looking for patterns across cases*

This stage identified patterns across the different cases. This aimed to explore which themes appeared most compelling and which ones helped to illuminate different cases. The researcher constructed a master table (found in the

Findings chapter) to represent the outcome of this stage and chose to use direct quotes from participants in order to help identify the themes in the original data. The themes within the master theme table were then explored using narrative accounts from specific participants, including verbatim extracts and a level of interpretation. The researcher took care to ensure, to the best of his abilities, that it was clear to the reader which were the words spoken by the participants and which were the researcher's interpretations.

3.3 Developing a method for using IPA as a comparison tool

This study explores the research question in relation to two groups and this implies that there could be some level of comparison between these groups. As mentioned previously one sub type within comparison studies is “to compare the similarities and differences of the conclusions obtained in alternative assessment methodologies” Shabani & Lam” (2013:160). This, in conjunction with the fact that an important aspect of IPA is searching for similarities and differences between the participants (Smith & Osborn 2008), led the researcher to develop a method based on looking at this sub type of comparison studies. Upon identifying the similarities and differences a further stage was added to the method. This stage was to look back at the original interviews to see whether the data supports the notion of the sub theme being a similarity or a difference or not. This aimed to ensure the findings had not been too far removed from the original data.

The researcher used the master tables constructed during the two IPA studies in order to identify the similarities and differences between the groups. The method is now outlined:

1. Construct one table incorporating the sub theme findings from the psychotherapists and counselling psychologists master tables.
2. Cross reference sub themes for counselling psychologists with relevant data from the psychotherapists sub themes.
3. Cross reference sub themes for psychotherapists with relevant data from the counselling psychologists themes.
4. Construct a master table to express the quantity of psychotherapists and counselling psychologists who spoke about each sub theme.
5. Identify which sub themes were present for 50 percent or more of the participants for both groups and label as similarities.
6. Identify which sub themes were present for one group and not for another and label as potential differences
7. Explore original data in an attempt to check if there is evidence to suggest the potential similarities and differences should not be labelled as so.
8. Discuss any connection between the similarities and differences across the groups.

4. FINDINGS

4.1 Overview

In this chapter the researcher will show the findings of the Interpretative Phenomenological Analysis for each of the two groups in relation to the research question:

“In what ways, if any, does psychiatric diagnosis influence the way psychotherapists and counselling psychologists work?”

Upon showing the findings for the two groups a further set of findings is presented. This further set of findings is the result arising from the comparison of the similarities and differences between the two IPA studies.

This chapter is broken down into three sections:

- Findings from psychotherapists
- Findings from counselling psychologists
- Similarities & differences between the two groups

4.2 Findings from psychotherapists

Five superordinate themes emerged from the data to form the basis of the findings:

1. Wrestling with diagnosis
2. Influence of diagnosis
3. Impact on formation of professional identity
4. Responsibility
5. Importance of the therapeutic relationship

The master table below shows the superordinate and subthemes that were found from the analysis of the data provided by the psychotherapist participants. The master table also provides quotes from the original transcripts to show the themes in relation to the raw data.

4.2.1 Master table of superordinate themes for psychotherapists

Superordinate theme	Sub theme	Participant	Page/ Line	Keywords
1. Wrestling with diagnosis	Helpful aspects of diagnosis	Natalie	P11, L5,6	"I think labels are necessary because it is a way of describing something"
		Linda	P10, L23 – 24	"the different diagnosis and can help give some useful pointers and describe what's going on"
		Alison	P6 L16,17	"kind of a diagnosis or they would say this person has been suffering with depression or anxiety"
		Lauren	P8 L 17,18	"every industry has jargon even the psychotherapy industry has certain phrases and words"
	Diagnosis is a hindrance	Natalie	P7 L6-11	"terminology are loosely, so loosely and so wide"
		Linda	P9 L8 – P10	"Overt symptoms of acute OCD"
		Alison	P4 L11 - 13	"there are different intensities and different levels"
		Lauren	P5 L18-25	"Case conferences, this is my view"

Superordinate theme	Sub theme	Participant	Page/ Line	Keywords
2.Influences of diagnosis	Not accepting client for treatment	Natalie	P15, L18,19	“Winnicott who said never ever have more than two or three of very sick patients”
		Linda	P8 L14	“I might attempt to find that I have not got space where I may have space for somebody else”
		Alison	n/a	n/a
		Lauren	n/a	n/a
	Feelings evoked by diagnosis	Natalie	P15 L14,15	“if they are coming from a psychiatrist what I do know is that they are going to be a very disturbed patient”
		Linda	P7 L1	“my initial reaction is like oh my god you know for this person is completely nutty”
		Alison	P10 L19,20	“no I actually quite like working with that level of intensity”
		Lauren	P8 L1	“certain words must be a trigger or must be a heart sink”
	Ways of working with clients	Natalie	P1 L27 – P2 L1	“someone coming along with a neurotic illness I would be dealing with very differently to someone with a borderline”
		Linda	P1 L10,11	“it does influence how I initially start working with them, how I feel about them”
		Alison	P13 L14,15	“I’m aware that you come with a diagnosis of depression”
		Lauren	n/a	n/a

Superordinate theme	Sub theme	Participant	Page/ Line	Keywords
3. Impact on formation of professional identity	Relationship between diagnosis and therapists experience and training	Natalie	P8 L24,25	“when I first started we would never of seen somebody who was suicidal you know but now that’s the norm”
		Linda	P1 L19,20	“I feel that I have more experience in and less experience in for example... eating disorders”
		Alison	P1 L7,8	“working from a person centered perspective , we tend to go with what the client brings”
		Lauren	P2 L8 - 11	“I kind of challenged what I had been given formally and actually got the psychiatrist to rethink their own perspective erm which is quite gratifying again if that’s the kind of thing that only comes with experience”
	Impact of therapeutic setting		P5 L25,26	“part of my own learning experience was to not be so in awe of that moment, that letter, that diagnosis”
		Natalie	P1 L16,17	“there are certain diagnoses that actually working in private practice would not be suitable at all”
		Linda	P3 L15,16	“I was so hugely concerned and erm erm erm to cut a long story short he subsequently agreed to an admission”
		Alison	n/a	n/a
		Lauren	P5 L1-3	“think one of the many benefits that I had had from working at the hospital is the fact that my, I suppose my exposure to medical terminology erm diagnostic tools

				and diagnostic thinking”
	In relation to referrer	Natalie	P5 L23,24	“anyway I talked to my friendly psychiatrist [laughs]”
		Linda	P9 L8 – P25 P5 L18	Anger “there is some safety in that knowing a patient is already under the care of a consultant”
		Alison	P10, L1-2	“she didn’t speak very fondly actually of the psychiatrist side of our profession [laughs]”
		Lauren	P2 L25-26	“I I would like to have an on going relationship with the psychiatrist”

Superordinate theme	Sub theme	Participant	Page/ Line	Keywords
4.Responsibility	Responsibility and safety for therapist	Natalie	P5 L24,25	“that I would actually go ahead with some safeguards for my personal safety, that I had somebody in the home”
		Linda	P3 L20,21	“the decision of whom he would have been seen would not of been me it would have been a psychiatrist.”
			P6 L19,20	“if I’m really honest I guess there is more of a wariness around certain areas than others”
		Alison	n/a	N/A
		Lauren	n/a	N/A
	Responsibility for patient	Natalie	P2 L20	“the patients safety that’s paramount”
		Linda	P2 L7,8	“with that as the primary diagnosis I might suggest that they be better placed with another therapist”
		Alison	P5 L11,12	“I don’t think it is necessarily the actual diagnosis I think it’s treating everybody as completely unique and individual”
		Lauren	P3 L15-17	“recently I have gone back to my notes almost to try and confirm to myself did I do I really still think that that patient was schizophrenic”

Superordinate theme	Sub theme	Participant	Page/ Line	Keywords
5. Importance of the therapeutic relationship	Relationship is more important than diagnosis	Natalie	P11, L21	“It distorts the relationship”
			P7, L21,22	“psychoanalytic psychotherapy as I’m sure you know is all about the relationship and there is so much focus on the relationship”
		Linda	P8 L1,2	“what all I need to remember is it’s about the relationship and how we’re able to meet somebody”
		Alison	N/A	N/A
		Lauren	N/A	N/A
	Importance of the therapeutic alliance	Natalie	N/A	N/A
		Linda	N/A	N/A
		Alison	P13, L1-3	“client I don’t think it was until she felt comfortable and I felt that we had a trusting relationship that she looked at what was really going for her”
		Lauren	P11 L9	“everything has to be gauged according to the person in the room with you”

Following the table above is a collection of passages from individual transcripts, looking at specific aspects of the superordinate themes in more detail. The researcher will be making interpretations upon the passages to help illuminate the question which is being investigated.

4.2.2 Wrestling with diagnosis

From the data, the first aspect which emerged was that there was a struggle for all the participants with regards to how they feel about diagnosis, and also about background information. The conflict became apparent as to whether having a psychiatric diagnosis was useful or a hindrance, this emerged as the participants seemed often to contradict themselves during the interviews. The researcher has chosen to concentrate more on how they wrestled with the concept of diagnosis, than with the other superordinate themes which emerged, as this was the most pronounced finding.

Natalie came across as confident that a psychiatric diagnosis is included in the whole background information provided by an external healthcare professional, and she felt that it was important to have as much of this information as possible;

“Well I don’t think an individual could necessarily be describing it in quite the way that a psychiatrist might describe erm so as I say I think labels are necessary because it is a way of describing something its whether err these labels then, it’s what the connotations are” (Natalie, P11, L4-7).

Natalie is showing how she feels that a diagnosis is a way of describing something that is going on for the patient. She is also expressing how a diagnosis provided by a

psychiatrist will be different than that of a client. Interestingly, Natalie then hints at the implications of a diagnosis, and it feels that this sentence helps to sum up her specific struggle with diagnosis, how it is useful but to be aware of the implications:

“The trouble is some terminology are loosely, so loosely and so wide and and I wouldn’t want to erm people say to me this one’s borderline, I think oh fine I work with borderline people all the time but there’s the range of borderline there’s the borderline who is dangerous” (Natalie, P7, L7-11).

Another negative aspect of psychiatric diagnosis for Natalie is how it attempts to put people into categories. There was a sense of frustration at how Natalie expresses people may talk about ‘borderline’ patients. By saying ‘there’s a borderline who is dangerous’ Natalie provides an example of a characteristic that the diagnosis of ‘borderline’ does not encapsulate.

One possibility that could be adding to her conflict is the different roles she has. In addition to being a psychoanalytical psychotherapist, she is responsible for finding training patients for psychoanalysts in training, and she talks about the level of detail that she wants from the clients. One possible explanation for this could be a sense of responsibility for both the client and for the psychoanalyst in training:

“I would first of all [want] a very very detailed application form that they have to fill in which covers all sorts of things from relationships with mother with father with siblings with grandparents of the whole history of their lives really” (Natalie, P4, L19-21).

This desire for as much background information as possible conflicts with her later statement:

“There’s partly why in psychoanalytic psychotherapy a lot of colleagues will not tell you very little if they are referring someone and one of the reasons is because it distorts the relationship you have with them right before they start. So if somebody says I’ve seen this man and this is my assessment that’s that’s sort of fair enough but if they tell you too much about erm what’s going on that stops something happening between you and the patient”. (Natalie, P14, L4-9).

It is interesting to note the slip in that sentence, she states ‘a lot of colleagues will not tell you very little’ it seems she did not mean to add the word ‘not’ into that sentence, which may also highlight the struggle that Natalie faces.

Like Natalie, Linda also felt that diagnosis helped to describe what is going on for clients:

“The different diagnosis can help give some useful pointers and describe what’s going on” (Linda, P10, L23-24).

Linda didn’t overtly express an opinion that patient experiences are difficult to be labelled, however one specific sentence in the interview alluded to this:

*“Yes there’s one that springs to mind and this particular patient for example if somebody came to me and they clearly displaying overt symptoms of acute OCD”
(Linda, P9, L8-10).*

The use of two verbs (overt and acute) suggested to the researcher that the diagnosis of 'OCD' may not have captured enough for Linda. Like Natalie suggested, there are different forms of 'borderline', Linda talks about different forms of OCD, therefore highlighting that a diagnosis does not provide enough information.

For Alison the struggle seemed more complex. Throughout the interview she seemed confident that diagnosis is not useful for her, she acknowledged the fact that it may have some benefits, but she seemed confident it did not serve a constructive purpose:

“So do I think a diagnosis has a real value? Yes in some cases, but it is not what I would personally choose to work with I would work with what they bring” (Alison, P1, L25 -26).

Alison found it easier to articulate the negative aspects of diagnoses; an important sentence seemed to be:

“I think it's very hard to label somebody with something unless you've worked with them and got to know them and got to know a bit about their life so I think my opinion is diagnosis and assessments tick boxes and don't necessarily think they have huge amount of worth erm. That's my opinion” (Alison, P3, L7-9).

Alison was extremely passionate when she spoke the above paragraph; she shook and wagged her finger as she spoke. The researcher recalls feeling that he was under attack by Alison, he hypothesised that maybe a reason for the feelings of being

attacked were her strong views on diagnosis and that she may have felt that the researcher was trying to push her into looking at the benefits of diagnosis.

The two paragraphs from Alison's interview seem to contradict one another, first she acknowledges that she feels diagnosis has a real value, yet in the second paragraph she expresses her view that diagnosis and assessments tick boxes, and that there is not a lot of worth in them.

The struggle seems to go further than this:

“so I don't know it's really difficult because my model we don't do we don't diagnosis we don't do assessments although I have experience of that and I been on you know quite a few workshops about assessments” (Alison, P11, L25 – P12, L2).

One possible reason behind the struggle for Alison could be in relation to her training. The above passage helps us to understand the predicament Alison may be in. 'Because of my model we don't do diagnosis, we don't do assessments' perhaps assessments and diagnosis are taboo in her training. She is a person centred counsellor and the researcher questions whether she is hiding behind her training in order to not be open to any other possibilities, which, in itself, seemed to be a contradiction of the work that therapists do. The researcher also found it interesting that Alison had elected to attend courses on assessment as her training does not 'do assessments', maybe she had been fighting against the struggle for some time. The struggle continued throughout the interview

“it's really hard it's a hard question and maybe that's something in my practice I should look at and maybe having a go, seeing somebody that I have a diagnosis and

full assessment before and actually seeing how that does impact because as I said recently in the last couple of years I haven't had that so maybe it would be quite useful for me to see if it how it would affect" (Alison, P12, L3-8).

The above paragraph was spoken in a quiet voice, and Alison appears to be reflecting upon the interview, possibly acknowledging the fact that she had closed something down by being so adamant that she is not influenced by diagnosis. She seemed to be admitting that the question may be more difficult than she had initially thought. The researcher also wondered whether the reason behind speaking in a quiet voice, when she said this, was a fear that this was betraying her training and orientation as a person centred psychotherapist.

The struggle for Lauren seemed far less than for the other participants. The passage below shows how she feels about the medical model and that diagnosis can be dangerous, as it can put people into boxes:

"That of course slightly flies in the face of the medical model that says aha schizophrenia aha obsessive compulsive, whatever the progno, the diagnosis is, you are in danger I would imagine you are danger of putting someone in a box, but then you know every, every industry has jargon even the psychotherapy industry has certain phrases and words that are used" (Lauren, P8, L14 -18).

The fact that Lauren said 'I would imagine' suggested that Lauren was trying to distance herself from this practice, so as to allow the researcher to interpret that she is speculating rather than talking from experience. So Lauren is highlighting the dangers of diagnosis, then goes on to excuse these dangers by comparing the

terminology of diagnosis to other industries. Another interesting passage that shows Lauren's struggle is where she reiterates the dangers of diagnosis, putting people into categories and treating them according to their diagnosis:

"I think one, one trap to fall into is to say oh yeah I know, I know how to do this I know how to deal with a depressive I know exactly what to say to an addict I know exactly, because I just don't think that that makes you the worst kind of psychotherapist actually the ones that do that, you have to I think you have to treat every patient that comes through the door as if you have [not]worked with a patient before, eliminate all the anxiety as I mentioned before completely fresh, attune to absolutely everything otherwise you're doing a disservice to the patient, I really think that. That was quite a long answer, sorry" (Lauren, P8, L3-11).

Lauren states what she feels makes the worst kind of psychotherapist, once again she is passionate about her belief in the way that diagnosis can close things down and she is showing that there is a lot of responsibility on the therapist to try to bracket out certain elements when working with a new client. Interestingly, there is a word that seems to be missing from the passage, which the researcher has inserted into this section. The researcher felt intrigued by this omission and wondered whether this too could be indicative of a struggle. The end of the passage is also interesting, as she states that 'she really thinks that' which seems significantly important as it emphasises her belief in what has been spoken. Following on from that, she apologises for the fact that her reply to my question was long, this made the researcher wonder about the struggle for Lauren even further. Lauren works both privately in her own consulting room but also at a private psychiatric hospital and

earlier she identifies that the majority of her referrals come from a psychiatrist, therefore it may be difficult for Lauren to say anything negative about elements of the medical model that she works in, even if she strongly believes that.

4.2.3 Influence of diagnosis

There were a number of common ways in which the participants verbalised how they are influenced by diagnosis. For some this seemed more apparent than for others. Two participants were forthcoming about how it impacts upon them deciding to take on a client for therapy.

Natalie spoke a number of times about this decision:

“the first, first decision should be should I take this person on because erm there are certain diagnoses that actually working in private practice would not be suitable at all” (Natalie, P1, L15-17).

Another example being:

“you have to look at your whole case load when you are taking somebody like something really ill on erm to how many of these can I take erm now you’ve probably read Winnicott who said never ever have more than two or three of very sick patients” (Natalie, P15, L16-19).

Both the above passages demonstrate Natalie’s decision to take a referral or not, and this can be based upon the diagnosis, but also demonstrates it is not simply the

diagnosis which influences this decision, but her entire case load. She reinforces her position by quoting Winnicott, which leads her to justify this decision on the basis of responsibility for herself, therefore in turn for the patient. This also emphasises the way she views her patients. Does she see someone with a specific diagnosis as a very sick child who needs more attention than a child that is not so sick? Meaning that if she takes on too many patients with diagnoses, that in her opinion means they are ‘very disturbed’ (P15, L15), she would be neglecting the other patients. Therefore, the second passage shows how Natalie is using her experience and training to justify the decision in a positive light.

Linda, however, seems to use her training and experience as a reason to not take on specific patients with specific diagnosis:

“if a consultant comes to me and says oh I have seen somebody and they start describing I might attempt to find that I have not got space where I may have space for somebody else” (Linda, P8, L13-14).

Linda grimaced as she spoke the passage, which indicated she may not be pleased with the fact that this is how she is influenced but, again, appears as if it came back to her experience and also to her confidence and again emphasises the struggle she faces.

The acknowledgement of an emotional response to certain diagnosis seemed to touch all the participants. Natalie spoke about the fact that if any patient comes from a psychiatrist then they are going to be ‘very very disturbed’ (Natalie, P15, L15).

Linda’s emotional responses were more apparent:

“if I’m honest yes, if I hear the word psychosis yeah I will think oh my god erm personality disorder erm and like I said eating disorder, like I said areas where I don’t feel as confident or experienced in but yeah if I’m really honest I guess there is more of a wariness around certain areas than others and maybe more of a judgement if I’m honest” (Linda, P6, L18-21).

Linda shows how the power of a specific word evoked an emotional response; she again talks about her confidence and inexperience as a possible reason for this reaction. As the sentence closed, the words ‘if I’m honest’ led the researcher to wonder what she would have said if she wasn’t being honest. When asked about what kind of judgement she might make Linda replied:

“well yeah you know my initial reaction is like oh my god you know for this person is completely nutty, excuse the erm, you know whilst trying to retain that unconditional positive regard” (Linda, P7, L1-2).

Here the repetition of ‘oh god’ shows how strong the emotional response is. The feeling that the person is ‘nutty’ suggested the level of panic or anxiety that is aroused within Linda. The use of the words ‘excuse the erm’ suggest that Linda felt ashamed that this is the response that is evoked within her. Linda then goes on to emphasise the struggle that is going on for her, she becomes tongue tied and stuttered, she then quotes one of the core conditions of person centred therapy showing that her response makes it difficult to remain true to her training.

Lauren only found it easy to talk about the emotional responses during her training; when she was asked to see a person diagnosed with schizophrenia she stated:

“Oh I mean when I got that instruction I remember thinking wow erm I’m in at the deep end errr I had I was on a placement so this was part of my training erm and this was my first patient, I mean I just didn’t think you would probably get any more err errr serious or more important” (Lauren, P3, L4 -7).

Lauren was on her placement at a hospital, and the use of the word ‘instruction’ shows how she felt about the referral, it was not a referral that was open for discussion, she had to see this person. It also highlights the anxiety that she felt. ‘Wow’ implies that she did not expect to see this person or maybe that this person should not be seeing her. She felt in at the ‘deep end’ and that there was nothing more serious or more important, could she be out of her depth and possibly drown? In order to protect her professionalism when referring back to this patient during the interviews, Lauren always reiterated that this was her first patient. Lauren found it more difficult to talk about the emotional responses that she feels now, and only spoke about them from a more detached perspective:

“I think on a subconscious level certain words must be a trigger or must be a heart sink or must be a you do respond to certain words and I’m trying to think what those words would be, I think I work very hard to consciously override that” (Lauren, P27, L26 – P8, L3).

She is providing a more general view and not actually stating that this is the case for her, however the fact she is working very hard to consciously override it, suggests that it is present for her.

Alison's emotional response seemed different to the other participants; so far, they all seemed to have a response that could be seen as negative, whereas Alison's response was more of enjoyment:

“I actually quite like working with that level of intensity I suppose and for me it was a really nice reflection on on I'm quite passionate about the model and the way I practice” (Alison, P10, L12 – 21).

The above passage was when Alison was speaking about a patient who she described as extremely suicidal and who had a number of different diagnoses though out his life. This passage suggests how she likes working with clients who are suicidal. She herself provides a rationale for this emotional response, being that she is extremely passionate about person centred therapy. Alison, for the most part of the interview, was adamant that a diagnosis does not influence the way in which she works at all, however contradicts that in a significant way:

“If somebody comes with a diagnosis of depression then I think you would bring that into the room and say I'm aware that you come with a diagnosis of depression can you tell me what that's like for you... so yeah in some ways maybe it would give you that foundation block but then then don't I think you find that anyway” (Alison, P13, L11-18).

Alison is stating that if she receives a referral letter with a diagnosis of depression, then she will start the first session with reference to the diagnosis. The passage is complicated because Alison starts with how she would open her session then seems to have a dialogue with herself by stating ‘but then don’t I think you find that anyway’. This may be due to the fact she has identified that she has contradicted herself, and realised that diagnosis does influence her and she is trying to tell herself it was not necessary for her to start the session in that manner. This again highlights the struggle that is going on for Alison.

Linda categorically states that she is influenced in the way that she works dependent on the background information by stating:

“I believe it does influence how I initially start working with them, how I feel about them” (Linda, P1, L10 -11).

She then goes on to provide an example of how she changes the way she works:

“I was knowledgeable enough and did find myself taking the time to research further into you know OCD, get some more sort of information and look up ways of working, but that didn’t tend to influence too much what went on in the sessions anyway, it returned to just about meeting the patient” (Linda, P13, L11 -18).

This highlights her anxiety regarding her abilities as a psychotherapist, she explains that it did not influence the sessions too much, meaning it must have, to some extent,

however, it was more important to concentrate on what she already knew was important.

4.2.4 Impact on the formation of professional identity

The participants' experience and / or training was mentioned in all the interviews. Interestingly, all the participants referred to their specific modality of psychotherapy within the interview, except Linda, who implied this by mentioning one of the core conditions of person centred therapy. This could be perceived that they were providing a philosophical justification to back up the views they were expressing during the interviews.

Linda talks about the relationship between her training and experience and diagnosis by stating:

“I feel that I have more experience in and less experience in for example... eating disorders, I don't consider that to be an area that I have a lot of experience” (Linda, P1, L19-20).

Linda went on to talk about her inexperience by saying:

“well one of the people I respected most on my training, one of the teachers he always said that it takes 20 years' time to make a good therapist (laughs)” (Linda, P7, L15-16).

Lauren talks more specifically about how she has changed with experience, and how this has influenced how she feels about diagnosis:

“my personality meant that in the very beginning if the psychiatrist says schizophrenia I assume that’s one hundred percent correct and part of my own learning experience was to not be so in awe of that moment, that letter, that diagnosis and sort of have the confidence in my own convictions, chances are I’m going to agree with the majority of what they say um but every so often you know, own your own, own your own work and so no, no I don’t, I don’t think this is quite right” (Lauren, P5, L23 – P6 L2).

This showed Lauren’s perception of the referrer, and how she is aware it is part of her personality that she wanted to believe that someone in authority would always be correct. She explains that experience has helped to shift that perception and to not close down other possibilities. The latter part of the passage shows how Lauren feels she should be confident to be able to challenge the diagnosis if she feels it is wrong, however, the stumbling of her words ‘own your own, own your own work and so no, no I don’t, I don’t think this is quite right’ suggests it is a frightening experience to actually do so. The other interesting part of this passage is that she does not say she would tell the psychiatrist she feels the diagnosis is wrong, rather that she will just think it.

Alison seemed to bring her training up throughout the interview. One interesting statement from Alison shows her annoyance at how people often view person centred therapists:

“I’m quite passionate about the model and the way I practice but it was a true reflection I feel on that it works you know because I offered what she felt she wasn’t getting from the other professions erm and she said to me you know you are quite challenging with me and you certainly give me lots of things to think about so it wasn’t that I was sitting there being all woolly and fluffy and nicey nicey as a person centred reputation seems to have” (Alison, P10, L20 -26).

This shows Alison’s passion for being a person centred therapist, and shows how she feels that her model allowed her to be able to help a client who had a diagnosis that could be perceived as complex. She then defends the position that she helped her, by saying that the client told her she was challenging. Alison then goes further to defend her model, and attacking the stigma she feels it has within the therapeutic community.

With regard to the common sub theme of the therapeutic setting, Natalie feels there are some diagnoses which should not be seen in private practice (P1, L16-17) and require the backup of a hospital (P7, L6-7), this is picked up by Linda who does work at a psychiatric hospital. She provides the story of someone coming for an assessment to be seen by an addictions therapist. The patient was subsequently diagnosed as psychotic:

“He absconded erm during the process and wanted to terminate the assessment and I was hugely concerned about this guy... he subsequently agreed to an admission... it was just hideous and that situation was a case where more information initially

would have been hugely helpful erm you know GP referral, anything anything anything which would of the decision of whom he would have been seen would not of been me it would have been a psychiatrist” (Linda, P3, L13-21).

Linda is expressing how difficult a situation this was for her due to the fact that there was no background information or diagnosis provided prior to being seen by her, and highlights the fact that she would not have chosen to see this patient if she had known he had a diagnosis of psychosis. The fact that there is the backup of a hospital setting and other professionals provides a sense of security for Linda. This is picked up again by Linda in relation to the referrer:

“There is some safety in that knowing a patient is already under the care of a consultant [psychiatrist] and that that that that they are linked into a support system so from that point of view” (Linda, P5, L18-19).

Linda is showing her relief that there is someone else who can see the patient, and that it provides some safety. It is interesting to note the use of the word consultant rather than psychiatrist, which the other participants used. This emphasises the authoritative position that the psychiatrists take within the hospital setting. Even though this brings comfort to Linda, she also feels this can be disempowering and can cause anger to be evoked within her. An example of this is where her work with a patient was interrupted abruptly by the psychiatrist because the patient was later diagnosed with obsessive compulsive disorder:

“I felt outraged that that wasn’t discussed with me and that I didn’t have an opportunity to talk it through with the patient that I was working with, I suppose I felt kind of you know if I’m honest I felt deskilled, somebody’s better than me and they don’t have faith in my abilities” (Linda, P9, L17-19).

So not only are the pros and cons of diagnosis a struggle for Linda, so is the way that she feels about the referrer, for her, the consultant psychiatrist.

Natalie’s perception of the psychiatrist was different, this, for the researcher, felt it had come with experience and the length of time working. She refers to a time when she was asked by a colleague to see a patient who had just been released from prison; she decides to speak to a psychiatrist regarding the situation:

“I talked to my friendly psychiatrist [laughs] and decided that I would actually go ahead” (Natalie, P5, L23-24).

Natalie was using the psychiatrist to get another person’s view on the referral before agreeing to see the patient. The use of the word ‘friendly’ suggested to the researcher that perhaps the majority of psychiatrists are not friendly and cannot be approached in this manner, possibly Natalie felt special that she had this kind of relationship with a psychiatrist. Natalie provides an insight into the fact she does not see the psychiatrist as an authoritative figure who must be obeyed, as Lauren told us she was ‘instructed’ to see a patient, Natalie refers to situations where she is referred a patient by a psychiatrist:

“I would say that erm if a psychiatrist for example phoned and said that I am seeing someone, they have had several suicide attempts erm I think that psychotherapy would help them erm the sort of things I would want to know before I would commit to that...” (Natalie, P2, L11-14).

This indicates she will want more information from the psychiatrist than simply being told that psychotherapy would be helpful for them. The word commit seems to indicate it is extremely important for Natalie that if she agrees to see someone that she continues with the work, therefore it is vital for her to feel the referral is an appropriate one, not just to take the word of a psychiatrist.

Lauren talked about how the training experience of working within a psychiatric hospital setting allowed her to be immersed in diagnostic terminology, and that she finds this useful in her practice now. It has also enabled her to feel a specific way about the referrer:

“So I’d say the referral letter and the referral conversation probably don’t influence me as much as they used to but I I would like to have an on-going relationship with the psychiatrist it’s just useful fleshing out information” (Lauren P2, L23,26.)

Here, Lauren is showing how her experience has helped to change the way she feels information contained in a referral letter, which could include a diagnosis, influences the way in which she works, however, due to the therapeutic setting of the psychiatric hospital, she has been working in, she feels she wants an on-going relationship with the psychiatrist, as, for her, this helps with the work she is doing.

The researcher wondered whether the fact she states that the majority of her referrals come from psychiatrists (P8L24,25) is also important for her to be able to continue to use diagnostic language, in order to maintain the relationship with the psychiatrist, which may provide another struggle for her.

4.2.5 Responsibility

All the participants seemed to show a sense of responsibility for the patients. For Lauren (P3, L15-17) this meant going back to her notes, from a long time ago, to see if she still feels the same way about a specific patient who was diagnosed with schizophrenia. For Linda, this included referring on to a different therapist if she felt they would be able to work better with a patient presenting with a specific diagnosis:

“I might suggest that they be better placed with another therapist who has more experience there” (Lauren, P2, L8, 9).

Natalie and Linda both talk about the responsibility for the patient, and they also speak about the responsibility and security for themselves. Natalie stated:

“Decided that I would actually go ahead with some safeguards for my personal safety, that I had somebody in the home when I was doing the assessment erm and I saw him and he was very, very disturbed man and I felt that all I could do with him, what what would happen would be he would be so even with his medication he would be so exercised in the sessions that he would go out and do something

whatever his feeling was he would go out and hit somebody in the street for example and so what we decided to do was refer him for a cognitive behavioural treatment”

(Natalie, P5, L24 – P6, L5).

This passage shows how Natalie ensured certain measures were taken prior to seeing a specific patient, which were for her security. Upon her assessment, she decided she was not the most appropriate therapist for him and referred him on for cognitive behavioural therapy. She justifies her decision by explaining that he was not only a ‘very, very disturbed man’ but also one who she felt became so aroused during her assessment, that he would become unsafe to other people after the sessions. She also, interestingly, used the words ‘so what we decided to do’ which implies that her decision to refer him onto another therapist was a joint decision. At first glance, this seems to indicate that it was a collaboration between Natalie and the original referrer, but it feels that the patient was included in this decision making process. Therefore, this passage shows how Natalie felt a sense of responsibility for the patient as well as for herself.

4.2.6 Importance of the therapeutic Relationship

The therapeutic relationship was a superordinate theme for all the participants, and they all seemed to emphasise that this was more important than the diagnosis.

Natalie says:

“Psychoanalytic psychotherapy as I’m sure you know is all about the relationship and there is so much focus on the relationship” (Natalie, P7, L21-22).

She also uses this to also justify her decisions to take on or not take on a patient. If she feels the patient cannot enter into a relationship with her, or another person, then she cannot work with them.

Linda states:

“There are certain areas that I certainly more an area of you know comfort, yeah comfort zone if you like and areas that you know initially I might think oh no, but if I were then to work with someone and that stuff emerges I actually find you know what all I need to remember is it’s about the relationship and how we’re able to meet somebody” (Linda, P7, L23 – P8,L2).

This allows us to see that certain diagnoses take Linda out of her comfort zone, and could influence her to choose not to work with specific patients, based upon their diagnosis (as discussed above). However, if these issues emerged during her work, she feels she just needs to stick to her training and remember that it is the relationship that is important. This, again, highlights the struggle for Linda, and the anxiety the specific words of a diagnosis can evoke.

For Alison, it is only when there is a good relationship that anything constructive can be done with the diagnosis which has been provided:

“I don’t think it was until she felt comfortable and I felt that we had a trusting relationship that she looked at what was really going on for her” (Alison, P13, L1-3).

4.2.7 Summary of findings of data from psychotherapists

From the data analysed, the researcher found that all participants agreed that diagnosis forms part of the background information often provided prior to seeing a client, for which there can be a number of other elements, including conversations with the referrer, family history and medication. All the participants who are provided with a psychiatric diagnosis prior to seeing a client are influenced to some extent by the knowledge in different ways, even when they are insistent that they are not influenced.

There was a struggle for all the participants with regard to how they feel about diagnosis. They were all able to talk about the disadvantages the presence of a diagnosis can cause, however, they were also all able to talk about specific benefits that it brings, and, for some, this struggle seemed apparent.

It was difficult for most of the participants to talk about the feelings diagnosis evokes for them today, it was easier to talk about their experience during training or about how they feel diagnosis affects other therapists. However, it did highlight that all the participants acknowledged that different diagnoses do evoke different responses within them. This ranged from anxiety to excitement. It also showed how specific diagnoses have a stigma attached to them and one of the participants (Lauren P11 L23-25), even commented on how perhaps therapists should be helping

to reduce this stigma, suggesting that possibly society's feelings towards specific diagnosis start with the treating clinicians.

The participants all, at some stage, refer to the importance of the therapeutic relationship between the client and therapist and how this is more important than diagnosis. It is not until a good therapeutic relationship has been established can anything constructive be done with the presence of the diagnosis.

4.3 Findings for the counselling psychologists

Three superordinate themes emerged from the data to form the basis of the findings:

1. Wrestling with diagnosis
2. Influence of diagnosis
3. Political and economic implications

The master table below shows the superordinate and subthemes that were found from the analysis of the data provided by the counselling psychologist participants. The master table also provides quotes from the original transcripts to show how the themes relate to the raw data.

This chapter contains the findings from the analysed data provided from interviews with four counselling psychologists. The data was analysed using IPA as outlined in Smith *et al* (2009). The table below provides the superordinate themes which emerged from the sub themes. Following on from the table is a collection of passages from the data in an attempt to further illuminate the themes which emerged. The researcher has made specific interpretations where appropriate.

4.3.1 Master table of superordinate themes

Superordinate theme	Sub theme	Participant	Page/ Line	Keywords
1.Wrestling with diagnosis	Helpful aspects of diagnosis	Nicky	P6 L7 P1 L10-11	“It can give you a heads up, possibly a heads up” “it is quite a useful tool, guiding point in terms of having an understanding of some of the clusters of difficulties”
		Ruby	P5 L23 P1 L5-6	“For some people it might feel quite a relief to have a label” “give me some kind of preparation I suppose as to erm the sort I might expect from seeing the patient for the first time”
		Jenny	P1 L20	“think it gives them some sense of comfort and understanding of what it, is wrong”
		Kathy	P2 L4 P6 L19	“somebody has already had an opportunity to give their opinion on the situation” “it’s a useful guide”
	Diagnosis is a	Nicky	P6 L12	“Sometimes work to undo the damage caused by a

	hindrance			diagnosis”
		Ruby	P6 L27	“try and unhook the diagnostic label from their self-regard”
		Jenny	P1 L9-10	“I don’t have a problem with diagnosis erm, what I have a problem with is badly diagnosed people”
		Kathy	P6 L4	“people can get it wrong and I think sometimes we forget that”
	Using diagnosis responsibly	Nicky	P6 L2	“My personality is disordered! There is something fundamentally wrong with me”
		Ruby	P8 L22-23	“your per personality is disordered I just think that’s such a bleak prospect to live with”
			P9 L1	“think that for some people come wanting that label for a variety of reasons sometimes quite an unhelpful and unhealthy reason”
		Jenny	P8 L10-11	“the issue is around the more contentious diagnosis particular the personality disorders erm schizophrenia, bipolar because the implications particular in regards to driving”

Superordinate theme	Sub theme	Participant	Page/ Line	Keywords
2. Influences of diagnosis	Direction of treatment	Nicky	P10 L23-24	“if you got someone with a diagnosis of bipolar disorder you might ultimately end up talking about the anxiety model but you would start with the bipolar model first because the bipolar stuff is the primary issue”
		Ruby	P1 L12-13	“the patient in the assessment might, might talk a lot more about anxiety and then my thoughts about the treatment plan will change”
		Jenny	P7 L18-19	“That’s what I’m saying I don’t know how we can talk about interventions without having an idea of what the diagnosis is I just don’t get it”
		Kathy	P2 L10-11 P2 L17-18	“if you are working in a structured way you are thinking about case conceptualisation, formulation, treatment plan so all those things you are thinking about anyway but when you have a diagnosis to start” “So if somebody is coming to you with a diagnosis now I may be thinking of the tests and scales I might want to use if I’m looking at disorder specific types of formulation so I would have that prepared as an extra to what I would normally do”
	Feelings evoked by diagnosis	Nicky	P7 L15	“I don’t want to see narcissists I equally not prepared to see anyone with anti-social personality disorder”
		Ruby	P10 L17-18	“I reeeally like working with some, if somebody comes

				with a diagnosis of OCD”
		Jenny	P2 L13 P6 L20-21	“I like borderline patients” “not great at people that kind of present with quite a chronic depression if I’m honest I find the monosyllabic they very draining because they can consume the room”
		Kathy	P4 L16-17	“you do realise how manipulative some people can be in terms of their presentation and how they attend as its part of the game”

Superordinate theme	Sub theme	Participant	Page/ Line	Keywords
3.Political and economic implications	Relation to colleagues	Nicky	P7 L8-9	“a psychologist challenging a psychiatrist then you get into all sorts of power dynamics”
		Ruby	P8 L21-23	“what do you do with that you get somebody who erm trained and educated and experienced in how people work or the psychology and psychiatry and go on to say that your per personality is disordered I just think that’s such a bleak prospect to live with and erm and its not the way I see people”
		Jenny	P2 L22-23	“mainly the people sent who people to me are people that I respect clinically so I don’t tend to have too many differences in regards to diagnosis”
			P1 L18	“I do often give the people I work with a diagnosis”
			P2 L24	“I’m a consultant counselling psychologist”
		Kathy	P6 L15-16	“I feel ok it really depends on who they are and your relationship with them just like in anything but I think its ok it’s all about how you go about it really”
			P8 L1-2	“I cannot make a diagnosis so unless someone else has stated they have a diagnosis I have to be careful to always write has symptoms of. The diagnosis has to come from the clients GP or um the psychiatrist”

	Economic pressure	Nicky	P4 L5-7	“on the nhs certainly it’s not scope for people to spend years and years deciding whether or not they are willing to engage in therapy we have to provide a service to the community and we have to use those services responsibly”
		Ruby	N/A	N/A
		Jenny	P5 L22-23	“we are in this economic situation where there is pressure you know let’s look at things like IAPT that are demanding a diagnosis etc”
			P11 L17-18	“if they see you privately they are paying lots of money to come and see me”
		Kathy	P7 L18-20	“There is pressure to make a diagnosis, well you have to be careful to say has symptoms of whatever disorder because for example insurance companies will cover the cost of treatment for specific um diagnosis and possibly won’t if that isn’t the case”
			P7 L11-12	“Yeah whereas people that may not have a diagnosis who may be you know equally distressed and struggling may not have access to a service because they don’t have a diagnosis so it can be a dangerous thing”

Following the table above is a collection of passages from individual transcripts, looking at specific aspects of the superordinate themes in more detail. The researcher will be making interpretations upon the passages to help illuminate the question which is being investigated.

4.3.2 Wrestling with diagnosis

From the analysis of the data a struggle seemed to emerge for the participants in relation to how they feel towards psychiatric diagnosis. From the data we can see they are all influenced by the presence of a psychiatric diagnosis prior to meeting the patient for the first time. Nicky stating:

“well I think it undoubtedly will have an influence” (Nicky, P1, L6),

Ruby informing the researcher:

“During the assessment I’ll ask around that diagnosis” (Ruby, P1, L6).

Ruby’s words indicate how she changes her assessment based on whether a diagnosis is present or not. When Jenny was speaking about whether she works differently depending on the diagnosis she stated:

“I’m sure I should say yes to that” (Jenny, P4, L26).

The researcher was curious as to why she had used the phrase ‘should say yes’. The researcher wondered whether Jenny liked to believe that she is not influenced but realises that, at some level, she is. Kathy stated :

“There is always going to be a clinical influence with any kind of information that you have before you see that person” (Kathy, P5, L7-8).

Later on, Kathy talked more about the influence and states:

“it certainly has a massive influence, you know there is a huge influence” (Kathy, P6, L1).

Kathy initially indicated there was some level of influence but later she used the word ‘massive’ to show how much she feels it does influence. The researcher wondered whether this fixed belief they all felt, that they were influenced by psychiatric diagnosis, could be linked to the sub theme of ‘Treatment dependant on diagnosis’.

- **Helpful aspects of diagnosis**

Each participant was able to provide at least two positive aspects to the usefulness of psychiatric diagnosis for them, Nicky stating:

“it is quite a useful tool, guiding point in terms of having an understanding of some of the clusters of difficulties and I think that’s an important point, some of the

clusters of difficulties that the client potentially will be suffering from, potentially being the other crucial word” (Nicky, P1, L10-11).

The researcher believes Nicky is trying to ensure she did not come across as someone who is in favour of psychiatric diagnosis when she is talking about how it can be useful. She is careful to use words which indicate that what she is saying is not always the same for everyone, or for every situation. The words ‘quite a useful tool’ suggest it is useful, however, perhaps it is not essential. She shows how psychiatric diagnosis can be a guiding point to being able to understand some of the difficulties the patient could be struggling with. She reinforces her words by saying ‘I think that’s an important point’ and reiterates the words ‘some of the clusters’ to suggest that it possibly could not be all of the clusters. Furthermore, she uses the word ‘potentially’ and, again, reiterates the word and then reinforces how she feels by saying ‘potentially being the other crucial word’. The word crucial also gives a sense of how Nicky feels, as to the researcher it felt more powerful than using a similar word such as ‘important’.

Needing to try and remain objective about psychiatric diagnosis when talking about the possible benefits also surfaced when Nicky later on stated:

“It can be helpful in the it can give you a bit of a heads up possibly give you a heads up” (Nicky, P6, L7).

When Nicky had said how it can give you a heads up she chose to amend the sentence by adding the word ‘possibly’. This once again reinforced the point that it is not necessarily the same for everyone.

Ruby provided an example of how the psychiatric diagnosis can be useful for both her, as the clinician, and for the patient. For the patient she stated:

“For some people it might feel quite a relief to have a label” (Ruby, P5 L23).

The researcher felt that what was meant for Ruby, when she was speaking in that moment, was how a label could provide the patient with reassurance from knowing others have felt a similar way to them. Earlier in the interview, Ruby had talked about how psychiatric diagnosis can be useful for her:

“...give me some kind of preparation I suppose as to erm the sort I might expect from seeing the patient for the first time” (Ruby, P1 L-6).

This sentence suggested Ruby was inferring that it was a good thing to know what to possibly expect from the patient. She is careful to use the word ‘might’ to ensure that it is not a definite. This sentence also shows how she is influenced, as she uses the words ‘some kind of preparation’. The researcher wondered about these words, as the interpretation could be that, in order to prepare for the patient, Ruby may be planning how to be with the patient, based on the psychiatric diagnosis. This provides a possible link again to the sub theme of direction of treatment and how this is influenced by the diagnosis.

Jenny seems to reiterate the view which Ruby showed, regarding how a psychiatric diagnosis can provide relief for a patient, she states:

“Think it gives them some sense of comfort and understanding of what it, is wrong”
(Jenny, P1, L20).

She continues to reinforce this view:

“so I think sometimes diagnosis is a relief, you think great and you know literally I have had more people say thank you when I have given them borderline personality disorder diagnosis than I have, I have had no one let me think, I don’t recall, I had one patient not so long ago who didn’t like what I wrote in a letter about a diagnosis but um I can’t recall really having any difficulty with anybody I work with in respect of the diagnosis I have given them I’ve often just had a sense of erm relief” (Jenny, P12, L11-14).

This passage shows how, again, Jenny feels that diagnosis can be a relief, and is careful to use the word ‘sometimes’. The passage, however, opens up an interesting perspective on diagnosis. Jenny talks about how she will give someone a diagnosis, and in this example, the diagnosis is of personality disorder. It opens up the conversation as to who can make a diagnosis, and to why someone makes a diagnosis. The researcher found it of interest how she talks about how patients have thanked her for providing them with a diagnosis. She then appears to stumble when she seems to want to indicate that no one has not been pleased with the fact she has provided a diagnosis, she changes her mind and states that one person was unhappy.

Interestingly, she states the person who was not happy was someone she saw as a patient a long time ago. The last part of the passage, once more, reinforces the fact that she has provided the diagnosis and how often it provides the patient relief. Jenny also expresses her view on the importance of diagnosis when she states:

“Listen, diagnosis I think is really key.” (Jenny, P8, L6-7).

This sentence was halfway through the interview and the interviewer perceived this to be spoken in a fairly authoritarian manner. The word ‘Listen’ at the start of the sentence led the researcher to interpret she was tired of expressing how she felt about psychiatric diagnosis by providing examples, and wanted to succinctly and firmly clarify her opinion on the matter.

Jenny also stated:

“We work in a world where I work with my colleagues and it’s a common language (Jenny, P1, L26-27).

This sentence shows that where she works the language of psychiatric diagnosis is common and that, possibly, in order to feel part of where she works, she needs to adopt this language, even though it goes against her training as she states later:

“The training focuses so much on the different therapeutic orientations but it doesn’t focus on diagnosis” (Jenny, P5, L6).

This echoed the words of Dudley, 2004 where she stated that she is aware of a strong desire to fit in, and the use of psychiatric diagnosis helps to enable that.

Kathy stated:

“I, I think when you have a diagnosis depending on where it is coming from, obviously GP or psychiatrist, there is an element that they have been seen before that somebody has already had an opportunity to give their opinion on the situation erm when you don’t have that I’m thinking very carefully about assessment I’m thinking very carefully about you know making sure I’m asking all the right questions to build a good picture” (Kathy, P2, L3-6).

An element of having a psychiatric diagnosis provided prior to meeting a client, which Kathy felt was beneficial, was that somebody had already provided their opinion on the patient. However, this highlighted that having a diagnosis already, could possibly change the way she conducts her assessment, as she is saying that when she does not have a diagnosis, she is thinking carefully about the right questions to build a good picture. This could indicate that when she has a diagnosis already from someone else, she is not so focused on being careful to build up a good picture. It is also interesting to note Kathy’s words ‘obviously a GP or psychiatrist’ suggest that, possibly, Kathy believes only those two professionals are able to make a psychiatric diagnosis.

Whilst referring to psychiatric diagnosis in a positive way, Kathy also acknowledged how it is not the most important aspect of her work:

“overall it’s a useful guide but for me it’s just that because again my focus is the subjective experience of the individual and I think that sometimes if you do become preoccupied with diagnosis you are not able to see beyond that and I think as a counselling psychologist it is very important to be able to park that to keep it in mind but to not really let that come the centre of the work” (Kathy, P6, L19 -22).

This passage appears to show more of a balance in relation to psychiatric diagnosis, Kathy is showing, like Nicky, that is a useful guide or tool, however, it is necessary to be able to bracket it, otherwise the dangers associated can occur.

- **Diagnosis is a hindrance**

The participants, in addition to being able to talk about the possible usefulness of psychiatric diagnosis, were all able to talk about how they feel it can be a hindrance. Nicky:

“Sometimes work to undo the damage caused by a diagnosis” (Nicky, P6, L12).

Nicky goes on to provide an example of this from her practice:

“so we would have to spend a long time kind of normalising so to feel happy and to get a bit excited is in no way manic and it took us a long time but there you would do

a lot of work undoing the damage a diagnostic label that had just been thrown out”

(Nicky, P6, L17-19).

Nicky explained how someone, who had been diagnosed with a bipolar disorder, had become worried to be anything other than depressed, in case she went into a manic phase. It suggests Nicky felt the diagnosis had limited the patient to being open to her human emotions and showed how the focus of therapy had, at times, been trying to undo these effects. Nicky shows, to a certain degree, her frustration and possible anger regarding this by saying the diagnostic label had ‘just been thrown out’. This implies that it was not thought through in relation to how this could possibly impact upon the patient.

A similar concern is spoken by Ruby;

“if a person sees themselves as erm having experienced depression therefore they are a depressed person or something like this over a longer period of time erm so that it has got into their way of seeing themselves erm I would try um try and suggest different ways of seeing themselves to try and unhook the diagnostic label from their self-regard” (Ruby, P6, L24-27).

Ruby is showing how a psychiatric diagnosis can become a way in which a patient could possibly see themselves and can become attached to their self regard. Ruby, like Nicky, shows that therapy can sometimes end up trying to undo the effects of the diagnosis for the patient. Her choice of word ‘unhook’ shows how far she believes a diagnosis can become attached to people.

Jenny makes a differentiation between a psychiatric diagnosis and someone who makes the diagnosis:

“I don’t have a problem with diagnosis erm, what I have a problem with is badly diagnosed people for one and I have a problem with people not naming diagnosis so there’s a secret underlying diagnosis that the team might know or someone knows but the actual patient doesn’t know erm and also I have a problem with if they do know a diagnosis how it is explained to them” (Jenny, P1, L9-12).

Jenny states at the beginning of this passage that she does not see diagnosis as a bad thing. She does, however, provide examples of how it can have negative connotations. She is possibly saying it is the human element which is attached to psychiatric diagnosis that she can find negative. Firstly, she talks about ‘badly diagnosed people’. The researcher found her choice of words interesting, as if she was angry towards the patients, who she feels were diagnosed incorrectly. Secondly, Jenny explains how she feels angry towards clinicians refusing to name a diagnosis to the patient, but the clinical team knowing, and thirdly, how a diagnosis is explained to the patient. Jenny provides an example later on that encapsulates many of her annoyances expressed above:

“I just had a patient actually just now, poor guy just found out someone thinks he got sort of err do you know what they haven’t even told me someone’s told, someone’s written somewhere to someone else so three or four people now think he may have a presentation of schizophrenia don’t know where it’s come from because I don’t see any evidence but it’s all over his notes so you know how does he feel he is looking at

me saying did you know they must told you and I'm like no, so not only does it make me look an idiot we just spent twenty minutes in the session trying to unpick it"(Jenny, P6, L9-13).

Jenny is showing how a current patient of hers informed her that someone else previously had made reference to presentations of schizophrenia and how he had only just found out. She shows empathy, perhaps even sympathy, for the patient as she refers to him as a 'poor guy'. This passage is important as it shows how Jenny is not only angry for the patient, but also for herself as a clinician. In fact, the researcher felt Jenny was more concerned about how it was for her, than the patient. She states 'do you know what, they haven't even told me' which seems to indicate she feels insulted and also may highlight how important Jenny views herself as a clinician. Jenny also expresses how she is left feeling that she looks like an idiot when she said 'not only does it make me look like an idiot'. Perhaps Jenny wants her patients to believe she knows everything about him and, possibly, that she does not want him to know she would ignore any previous diagnosis made. The researcher also wondered whether Jenny was angry that twenty minutes of a session was used to explore what this may mean for the patient. One possible reason for her anger could be that the way in which she was expecting to conduct her session had to be changed. Possibly, Jenny is showing how she does not like working with what emerges during a session; instead, she prefers to work with an agenda.

It is also interesting to note that twenty minutes was used to 'unpick it'. This implies that twenty minutes would be a long time to discuss this. The researcher was struck

by how important this sounded for the patient in question and questioned if twenty minutes would have been enough time to explore what this would mean for him.

The researcher was curious as to how this story may have been different if the diagnosis in question was not schizophrenia, but anxiety or depression, and somewhere in the patient's notes it stated the patient may have a presentation of anxiety or depression. It opens up the question as to whether Jenny would have felt like an idiot for not knowing that someone had written this previously, and how the patient may have reported it left him feeling.

The researcher found it noteworthy that Jenny could feel insulted by not being told about a possible diagnosis in a patient's history, as she had previously explained she ignores the diagnosis included in any referral letter:

I'm going to go against what I just said a minute ago because actually when someone sends me a referral I ignore their diagnosis because I need to view in my own you know I'm more than capable of making a diagnosis (Jenny, P2, L14-16)

This passage showed how Jenny is aware she is contradicting herself by saying she would ignore any diagnosis in the referral letter, which highlights the struggle she has with psychiatric diagnosis. She continues to provide a rationale as to why she ignores the diagnosis by saying 'because I need to view in my own' then stops and changes the sentence. The researcher wondered whether she was going to say she needs to view the diagnosis in her own mind, and is curious as to why she did not continue with this sentence, instead, changing her stance into a more authoritarian

position and possibly belittling the referrer, as if she is saying she doesn't need them to tell her what the patient is diagnosed with, as she is 'more than capable of making a diagnosis'.

Kathy highlights a number of points regarding the dangers of psychiatric diagnosis when she states:

"I'm on the side of I like to have as much information as possible but as we say err if that is just somebody else's take on it sometimes we are all human we can have a different perspective, different people can present you know the one session they can be in a different place that particular day so you know people can get it wrong and I think sometimes we forget that because you can become preoccupied with what has been what information you have received" (Kathy, P6, L1-5).

In this passage, Kathy is showing her position regarding background information and diagnosis; she likes to have as much information on a patient as possible, and then continues to discuss the negative implications that could be associated. Firstly, she acknowledges it is simply somebody else's perception of the patient and states that we are all human, therefore our perceptions will always be different. She is also making reference to the fact that humans can get things wrong, and reinforces the importance of this point by saying 'sometimes we forget that'. This could be suggesting how we may perceive those who make a diagnosis as an authority figure and possibly could not ever get it wrong. Lastly, in this passage, Kathy expresses her view that we can become preoccupied with 'what has been' perhaps she is meaning that a client's thoughts, feelings, experiences and way of being, can change from

time to time, and are not always fixed, however, a psychiatric diagnosis may provide someone's opinion of the client at a specific time, which may be not a currently accurate representation. Kathy is contemplating that clinicians may become too concerned with the patient's past, which can close down experiencing them in the current moment.

- **Using diagnosis responsibly**

Three of the four participants talked about how it is important that diagnosis is used responsibly and the implications it can have if it is not. Nicky spoke about her opinions on using the psychiatric diagnosis of borderline personality disorder:

“when you are looking at a diagnosis of borderline personality disorder and indecently I would never write in any of my reports that someone has borderline personality disorder I would say enough to make it evident but I wouldn't... because I think it is a label that is useful for the clinicians often but can be quite destructive for the client” (Nicky, P5, L22-24).

Nicky is showing she may allude to the fact she feels a patient should have a diagnosis of borderline personality disorder, but would not specifically use the wording of the diagnosis. Her choice of word 'indecently' is very subjective and the researcher wondered if she meant this word to mean offensively or improperly or does she mean that she would not use the word at all? She provides a reason for not wanting to use the diagnostic terminology by saying this specific diagnosis can be

for the clinician's benefit rather than the client. Upon elaborating on the point of how this diagnosis can be destructive for the client, she states:

“Well I think the very term personality disorder my personality is disordered! There is something fundamentally wrong with me” (Nicky, P6, L2).

Nicky, here, is showing how she feels about the wording of this diagnosis. She feels that saying someone has a personality disorder is akin to saying this person's personality is disordered, which for Nicky, suggests there is something fundamentally wrong with the person. This provides an insight into how a diagnosis can be interpreted by someone and opens up the question as to how a person may feel if they believe they are being told that there is something fundamentally wrong with them.

Ruby seems to share a similar view to Nicky, she states:

“what do you do with that you get somebody who erm trained and educated and experienced in how people work or the psychology and psychiatry and do on say that your per personality is disordered I just think that's such a bleak prospect to live with and erm and its not the way I see people,” (Ruby, P8, L21-23).

Like Nicky, Ruby is showing how the diagnosis of personality disorder is similar to saying someone's personality is disordered, and she feels that is a very difficult view of oneself to live with. Her sentence also opens up an important aspect regarding the position of the person making the psychiatric diagnosis. This person is trained and

experienced in the way people work, therefore Ruby is possibly questioning how difficult it may be to challenge the person, or to not see yourself in the way that this educated person has described. Ruby also goes on to show her position on this specific diagnosis when she says the way she had just discussed it is not the way she sees people.

Both Nicky and Ruby were able to talk about their views on personality disorders and how they feel a responsibility to how this diagnosis is used. Where Nicky took the position that she would not name the diagnosis but write enough for another clinician to consider the diagnosis, Jenny takes the opposing view:

“I have a problem with people not naming diagnosis so there’s a secret underlying diagnosis that the team might know or someone knows but the actual patient doesn’t know” (Jenny, P1, L10-11).

Jenny also provides a contrary position to Nicky and Ruby regarding how she feels a diagnosis or personality disorder is received by patients where she states:

“...I have had more people say thank you when I have given them borderline personality disorder diagnosis...” (Jenny, P12, L11-12).

Ruby and Nicky expressed the view that providing someone with the diagnosis of personality disorder has associated negative connotations; Jenny is stating that she feels patients are pleased. Interestingly, Jenny earlier on states:

“I sound like I diagnosis everyone with a personality disorder” (Jenny P9 l5).

This raised the question as to whether Jenny feels she is diagnosing large numbers of people with a personality disorder because a number of clinicians, such as Nicky and Ruby are not, or could there be another reason for this. One reason could be that Jenny previously had stated:

“I like borderline patients” (Jenny, P2, L13).

Jenny also provides an insight into another aspect of the importance of using psychiatric diagnosis responsibly:

“The issue is around the more contentious diagnosis particular the personality disorders erm schizophrenia, bipolar because the implications particular in regards to driving” (Jenny, P8, L10-11)

The researcher felt this could possibly be an important point and wondered what the implications of specific diagnosis are in relation to driving. This was not explored further in the interview but investigated further in the discussion chapter.

- **Who can make a psychiatric diagnosis?**

An interesting question emerged from two of the participant’s interviews, in relation to who can, and who cannot, make a psychiatric diagnosis. Kathy was speaking about insurance companies funding specific disorders and she stated:

There is pressure to make a diagnosis, well you have to be careful to say has symptoms of whatever disorder (Kathy, P7, L18-19).

Upon exploring what Kathy meant by saying ‘well you have to be careful to say has symptoms’ she explained:

“As a counselling psychologist I cannot make a diagnosis so unless someone else has stated they have a diagnosis I have to be careful to always write has symptoms of. The diagnosis has to come from the clients GP or um the psychiatrist” (Kathy, P8, L1-2).

Kathy is showing she is not able to make a diagnosis and implies that she is only able to contribute to a GP or psychiatrist’s opinion to make a diagnosis. This is very different to Jenny’s view:

“I do often give the people I work with a diagnosis” (Jenny, P1, L18).

Jenny is stating that she provides the diagnosis and so brings an opposing view as to who can, and who cannot, make a psychiatric diagnosis. The added word ‘do’ affirms her position that she provides a diagnosis. One reason, perhaps, for her reinforcing the fact she does provide a diagnosis could be that she is aware of how other counselling psychologists view their profession providing psychiatric diagnoses.

4.3.3 Influence of psychiatric diagnosis

- **Direction of treatment**

Each of the participants talked about how a diagnosis dictates the direction of therapy, this appears to be the most prominent observation as to how psychiatric diagnosis influences the way counselling psychologists work.

“if you got someone with a diagnosis of bipolar disorder you might ultimately end up talking about the anxiety model but you would start with the bipolar model first because the bipolar stuff is the primary issue”. (Nicky, (P10, L23-24).

Nicky is showing that if she receives a referral for someone with a diagnosis of bipolar disorder she would start psychotherapy with a treatment model designed for bipolar disorder. She does acknowledge that your treatment plan may shift as you get to work with the patient; however, it seems important to acknowledge how the start of psychotherapy is influenced by the presence of any psychiatric diagnosis. Nicky calls the ‘bipolar stuff’ the primary issue and the researcher feels she used this description as it is the issue which was identified first. She chose not to call it something relating to how important it is to the patient, or how it is the most debilitating issue which was identified. Instead, it is simply the first issue, therefore, that is why she would start with a treatment designed specifically for that. Ruby appears to talk in a similar way about the first appointment with the patient, she stated:

“If the referral letter originally mentioned depression and the patient in the assessment might talk a lot more about anxiety and then my thoughts about the treatment plan will change” (Ruby, P1, L11-13).

The fact Ruby says her thoughts about the treatment plan may change, suggest she already had a view on how she will work with the patient, based upon the diagnosis of depression, which had been provided prior to seeing the patient. This may indicate that, for Ruby, there is a specific treatment plan for people with a diagnosis of depression, and a different treatment plan for people suffering with anxiety. This also shows how Ruby is confident that if she feels someone is more anxious than depressed, then she is able to shift the way in which she works. This suggests that the diagnosis provided prior to seeing the patient is able to be adapted in her mind. Jenny provides a very strong view on how the diagnosis dictates the treatment plan and this is mentioned in a number of different ways during the interview.

“That’s what I’m saying I don’t know how we can talk about interventions without having an idea of what the diagnosis is I just don’t get it. I used to say this to all my staff they used they used to go rambling away with regards to interventions I’m like errr I don’t know how you got down there when I’m back here because I still want to know a diagnosis” (Jenny, P7, L18-21).

Jenny is expressing her opinion that you cannot implement any therapeutic intervention without knowing the diagnosis. The way she says “I don’t know how we can talk about interventions” goes further than how Nicky and Ruby feel. Jenny is saying that before you can talk to colleagues or to the patient about how you are

going to possibly work you need to have a diagnosis. There also seemed to be an element of power and control emerging from the passage with regard to Jenny and her staff.

Kathy stated:

“I think it does, I think it definitely can influence the plan or at least the way in which you carry out your assessment” (Kathy, P2, L15).

Kathy starts by stating how she believes it can influence the treatment plan, then changes the choice of wording to include the word ‘definitely’ showing how she is more confident that it does influence. It is interesting to note though, that she chose the word ‘can’ instead of ‘does’. Selecting the word ‘can’ implies it is not always this way. Kathy is showing how it can influence the treatment plan and / or the assessment. Kathy provides more understanding of this belief that it can influence the way an assessment is carried out:

“So if somebody is coming to you with a diagnosis now I may be thinking of the tests and scales I might want to use if I’m looking at disorder specific types of formulation so I would have that prepared as an extra to what I would normally do like PHQ and GAD erm and also just the areas that you are looking to inquire about you can perhaps gain more depth if you think somebody already has already been given a diagnosis whereas when they don’t have a diagnosis I think you are more having to cover a lot of ground because you don’t have that focus” (Kathy, P2, L17 – 21).

Kathy is showing how she may include specific psychometric tests to use in the assessment and her choice of tests would be dependent on the diagnosis which had been provided. The phrase ‘disorder specific types of formulation’ provides further insight into this; could this be showing how her formulation could already be predetermined by the diagnosis, as she is entering the assessment with that already in mind? Kathy also shows how the diagnosis provided may influence the specific areas she may focus on in the assessment. The last part of the above paragraph shows that Kathy feels, if there is no diagnosis present, then there are more areas to look at during the assessment, again confirming that a diagnosis provided a focus for Kathy’s assessment. It also shows possibilities for other issues may not arise if there is already a diagnosis made, as she will not be exploring as many different areas in the assessment.

- **Feelings towards patients**

Different feelings towards patients emerged for the participants when talking about specific diagnoses, some of these feelings were positive and some were not.

Nicky explained that in the NHS you cannot choose to not see somebody. However, talking about the private sector she states:

“privately absolutely I don’t want to see narcissists I equally not prepared to see anyone with anti-social personality disorder” (Nicky, P7, L17-18).

Nicky is forcefully stating her position with regards to who she will not see, as a patient, in the private sector. The choice of word ‘absolutely’ shows how she does not see someone who has a diagnosis of narcissistic personality disorder. She

continues to show that she also would not see someone with the diagnosis of anti-social personality disorder. This led the researcher to ponder about how she feels regarding other diagnoses in the personality disorder category within the diagnostic criterion. Nicky does go on to say how she has had personal experience of narcissism (Nicky, P7, L16) and how this has reinforced her decision not to work with patients with this diagnosis. The researcher wonders whether this personal experience was with someone or some people who have had the diagnosis of narcissistic personality disorder or whether she felt they should be diagnosed. Nicky also explains it is not just the diagnosis that can evoke this response, she states:

“if I see warning flags in the referral in that direction and it won’t be necessarily in the diagnostic label but maybe just other things that they have said that could be indicative of something in that direction I may well pass it on” (Nicky, P7, L21-23).

This shows how not only does the diagnosis evoke a response that leads Nicky to refusing to see the patient, but also how background information can influence her too. It is interesting to see how Nicky, in this sentence, does not simply use the word diagnosis; instead, she chose the words ‘diagnostic label’. This could suggest that, for Nicky, the diagnoses of narcissistic personality disorder and anti-social personality disorder are more than just a diagnosis, they are a diagnosis and a label and this opens up the debate surrounding labelling and its implications.

Ruby talked about how she would not see anyone who felt *“too close to home”* (Ruby, P9, L25). She provided an example which was not based around diagnosis, instead, was more surrounding the patient’s certain experiences feeling similar to

Ruby's. Ruby, however, did provide an example of how a diagnosis can evoke certain feelings within her:

“I reeeally like working with some if somebody comes with a diagnosis of OCD or if they talk about it themselves oh my heart errrm is errrm err is issss errm perfectly happy with that and I think oh great you know, I know we are going to be able to make so good progress here... because I think mostly you can, you know or we can erm so so if its OCD then in, in a referral letter I think oh great you know I will be great” (Ruby, P10, L17-21).

The start of this passage begins with Ruby emphasising the word ‘really’, her face lit up when she started the sentence. She is expressing how she feels when a patient comes with a diagnosis of OCD. There seems to be much excitement and enjoyment at this prospect for Ruby. She is also showing it is not just the diagnosis which evokes this response within her, but also if the patient starts to talk about OCD. Ruby’s description of how she feels is very interesting, she describes her heart as being ‘perfectly happy’, she stumbles to find the words to describe how her heart is feeling. The words ‘perfectly happy’ seemed a curious choice. The researcher considered whether this could be the top level of ‘happiness’ without substituting the word happy for another word for example ‘ecstatic’. The researcher then questioned if any other word used to describe a feeling evoked in relation to a patient’s suffering would be appropriate. Possibly her choice of words was to try to reduce the risk of sounding as though she is not empathetic towards the patient’s issues whilst still conveying her feelings. Ruby provides one reason as to why this feeling is evoked within her when she states she feels they are able to make ‘good progress’ when

working with OCD, and by saying ‘because I think mostly you can’ then correcting herself to say ‘we can’ suggests she is trying to bring the work back to being about the patient and not about her, as the therapist. The last part of the sentence provides another insight into this, where she states that if OCD is in a referral letter ‘I think oh great you know I will be great’. Firstly, she is saying she feels ‘oh great’ reconfirming what she had already said, but goes on to imply that she will be great, perhaps this shows how she feels she is good at helping people with OCD, it also reinforced the struggle which emerged in the previous sentence, that the work is not about her, but about the patient coming to see her.

Jenny, as mentioned previously, had stated she likes borderline patients, she continued:

“I am probably one of the few people who actually enjoy working with borderline personality patients” (Jenny, P2, L13-14).

This sentence suggests that Jenny sees herself as being different from many of her colleagues, which could provide a reason as to why she likes working with patients diagnosed with this specific disorder. Previously, she had confirmed she feels different to many of her colleagues when she stated:

“I don’t probably sit where a lot of counselling psychologists sit” (Jenny, P1, L4-5).

And

“I’m odd, there’s nothing kind of normal about me in the world of counselling psychology because of where I ended up in the NHS” (Jenny, P10, L14-15).

Another rationale as to why she likes working with patients with a diagnosis of borderline personality disorder could be illustrated where she states:

I have had a lot of borderlines and within the space of three, six months have made quite significant improvements, so there you know that’s good for them (Jenny, P4, L23-24)

This suggests Jenny feels that she is good at working with this diagnosis. The end of the sentence suggests a generalisation that she makes towards patients with a diagnosis of borderline personality disorder. She is saying making significant progress in three or six months is good for these patients. This could indicate that for Jenny, when she receives a referral letter with the diagnosis of borderline personality disorder, she feels if they make improvement, whatever the word ‘improvement’ means to Jenny, in this time frame, would indicate the work has been successful.

Kathy was able to speak about how she can sometimes wonder whether someone has presented in a specific manner in order to get a diagnosis for an agenda, which may be different to that of the person diagnosing, and also to her, as a clinician:

“you do realise how manipulative some people can be in terms of their presentation and how they attend as its part of the game so you got be careful it’s part of the tick box I think” (Kathy, P4, L16-17).

Instead of saying ‘you realise’ Kathy inserted the word ‘do’ which seems to reinforce how strongly she feels regarding this. She explains it can be part of a game or that they are ticking specific boxes for whatever agenda. She then ends the sentence with the words ‘I think’ which indicates that even though she may feel this way, she is not totally sure, and so perhaps she is suggesting she keeps this in the back of her mind when she feels it could be a possibility.

4.3.4 Political and economic implications

- **Relation to colleagues**

When speaking about a psychiatrist who she felt always diagnosed inappropriately, Nicky questioned whether you should challenge the diagnosis; she provided the statement:

“a psychologist challenging a psychiatrist then you get into all sorts of power dynamics” (Nicky, P7, L8-9).

The researcher felt that Nicky’s statement could provide two different interpretations. The first possibility could be that Nicky is suggesting there is a hierarchy of authority within mental health, and that the psychiatrist is more powerful or senior than a psychologist. The second, surrounds who is able to make a diagnosis and whether a psychologist is in a position to be able to question the diagnosis. The researcher felt Nicky’s words were suggesting both of these interpretations.

Ruby has already provided an example of how patients and / or psychologists perceive the person who has made a diagnosis when she stated:

“what do you do with that you get somebody who erm trained and educated and experienced in how people work or the psychology and psychiatry and go on to say that your per personality is disordered...” (Ruby, P8, L21-23).

Ruby spoke the above passage in a quieter voice and the researcher wondered whether this was due to the fact that, earlier in the interview, Ruby had explained that the majority of her patients are referred to her by psychiatrists in the building where the interview was taking place (Ruby, P3, L13 - 14). Therefore, she may feel she should not be saying that she does not agree with using specific diagnoses. The passage reflects how difficult it may be to do anything other than to accept a diagnosis, because of the perception that the person who has provided it, is trained, educated and experienced.

Jenny stated:

“mainly the people sent who people to me are people that I respect clinically so I don’t tend to have too many differences in regards to diagnosis” (Jenny, P2, L22-23).

Jenny is showing that she, on the whole, only receives referrals from people who she respects clinically, and that is the reason why she does not have too many differences

in regards to diagnosis. The researcher felt this appeared to be a very black and white manner of thinking; If you respect someone clinically then you would not disagree with their opinions. Whereas, it could, perhaps, open up the possibility that there could be more room for discussion surrounding diagnosis. This also seemed to contradict Jenny's point that she often provides a diagnosis for patients. Perhaps Jenny only feels there is a difference in regard to diagnosis if someone has already made one, not the fact that she provides one for someone who has previously been assessed as not having any psychiatric diagnosis.

Kathy spoke about how she deals with differences of opinion surrounding a diagnosis provided by someone else, she stated:

"I feel ok it really depends on who they are and your relationship with them just like in anything but I think its ok it's all about how you go about it really" (Kathy, P6, L15-16).

Kathy did not speak about any power dynamics, instead, showed how it is dependent on your relationship with the person who has made the diagnosis. She explains how this is the same in dealing with any situation. She stresses the important aspect is how you go about speaking to them about the subject. Kathy and Jenny came across as confident to speak about their thoughts to the person diagnosing, whereas Nicky and Ruby appeared to be less confident.

The researcher believes Nicky and Ruby were suggesting there is a hierarchy, with the psychiatrist at a more senior level to them, therefore, finding it difficult to be able

to discuss the possibility they believe someone has been misdiagnosed. Kathy explained that the relationship between the person who has made the diagnosis and her, as the clinician, is like any form of relationship, therefore felt confident to be able to enter into a dialogue with regard to a client's diagnosis. Jenny appeared to be angry towards the possible power dynamics Nicky and Ruby discussed. Jenny seems to be making a statement that she is a "consultant psychologist" (Jenny, P2, L24) which, perhaps, could be interpreted as more important than her role as a counselling psychologist. The researcher wondered if this was a defence as to how she also sees counselling psychologists, which would indicate that she also believes there to be some hierarchical system of power within mental health. This is backed up when she states:

"there was only my chief psychologist in the trust I was in and I was his deputy no one else around me were all coun, clinical psychologists and they automatically assumed I must be a clinical psychologist which is interesting, I said why must I be and they say well the way you talk, the way that you understand the mental health system, the diagnostic system and the legal system and the medical system" (Jenny, P10, L16-19).

This passage was of interest, as perhaps Jenny wanted the researcher to know she held a senior position within the NHS as the chief psychologist's deputy. The passage is confusing as the researcher believes she wanted to say she was the only counselling psychologist within the team, and that all the other psychologists were clinical, yet the passage does not make sense; she stumbles on whether she was wanting to say counselling or clinical, and also there are a lot of grammatical errors

which left the researcher confused as to what she was saying and meaning. The researcher interpreted this as, possibly, she was confused as to whether what she was saying was accurate or not. The passage continues, showing how the clinical psychologists assumed she was a clinical psychologist as well, and provides her explanation as to why they believed so. This could be interpreted as a counselling psychologist should not understand the mental health, diagnostic, legal and medical systems. The researcher felt Jenny held the opinion that a clinical psychologist was more 'senior' than a counselling psychologist. The researcher also questioned whether she regretted training to be a counselling psychologist and perhaps wanted to be a clinical psychologist instead. This may explain why she is more concerned with providing a psychiatric diagnosis for all her clients.

- **Economic pressure**

Jenny was able to talk about how there is a demand for clinicians to diagnose within the NHS:

“we are in this economic situation where there is pressure you know let’s look at things like IAPT that are demanding a diagnosis etc” (Jenny, P5, L22-23).

Jenny is suggesting that the IAPT service is driven by diagnosis. One possible reason could be that it is their opinion that in order to offer the most appropriate therapy for the patient, a diagnosis is required. This may be a justification as to why, throughout the interview, Jenny had been speaking about the importance of making a diagnosis, especially as Jenny had made numerous references to being the head of specific psychological services during the interview (Jenny, P5, L13, P6, L4, P10, and L13).

The researcher wondered whether the fact she had been under financial pressure to keep costs low had influenced her opinion of the necessity for diagnosis to be made. When speaking about the private sector Jenny states:

“If they see you privately they are paying lots of money to come and see me” (Jenny, P11, L17-18).

The researcher also wondered if this could be another reason why Jenny is keen to provide a diagnosis for her patients. Could it be that, as she feels it costs a lot of money to see her, she needs to provide value for money, and could providing a diagnosis be a way of doing that? It is interesting to note how the sentence commences with Jenny speaking about clinicians in general, where she states ‘if they come and see you’ but ends by being personal and about Jenny where she states ‘come and see me’.

Nicky also speaks of these pressures within the NHS:

“on the nhs certainly it’s not scope for people to spend years and years deciding whether or not they are willing to engage in therapy we have to provide a service to the community and we have to use those services responsibly”(Nicky, P4, L5-7).

Nicky is showing how the NHS does not have the funds to be able to work with patients long term. The researcher wondered whether this helps to understand the pressure that Jenny was talking about in the NHS to diagnose, especially as all the

counselling psychologists interviewed had shown the direction of the treatment they provide is dependent on the diagnosis.

Kathy talks about the economic pressure within the private sector in relation to diagnosis:

“There is pressure to make a diagnosis, well you have to be careful to say has symptoms of whatever disorder because for example insurance companies will cover the cost of treatment for specific um diagnosis and possibly won’t if that isn’t the case” (Kathy, P7, L18-20).

Kathy is showing that insurance companies will often fund specific disorders and not others, therefore, perhaps, there is a pressure to state someone has a specific diagnosis in order to be able to see them for therapy. The researcher noted Kathy used the words ‘well you have to be careful’ instead of stating that she has to be careful. This perhaps is due to Kathy not wanting to admit she may give in to the pressure, to ensure a patient receives the treatment, by stating a diagnosis that she knows will enable the funding, as opposed to saying the truth and the patient not being funded for any treatment. It is also of interest that Kathy uses the phrase ‘symptoms of whatever disorder’, this is explored later. The researcher was curious as to the fact Kathy inserted an ‘um’ in between ‘specific’ and ‘diagnosis’. The researcher believes Kathy was possibly making the connection for the researcher’s benefit, due to the nature of the research question, between the words ‘disorder’ and ‘diagnosis’.

Kathy continues describing the pressure when she spoke about how a diagnosis can enable someone to be able to access other services or benefits:

“Yeah whereas people that may not have a diagnosis who may be you know equally distressed and struggling may not have access to a service because they don’t have a diagnosis so it can be a dangerous thing” (Kathy, P7, L11-12).

Kathy here describes diagnosis as a ‘dangerous thing’ and the researcher wondered for whom it was a dangerous thing. There is the possibility Kathy was implying it is a dangerous thing for the clinician, as they may feel someone does not meet all the criteria for a specific diagnosis but may want them to be given that diagnosis in order to be able to access the help that will be available to them, and will potentially help them.

4.3.5 Summary of findings of data from counselling psychologists

The findings from the study highlight that for all the participants there is a struggle in relation to how they view the use of psychiatric diagnosis. All were able to discuss potential benefits within their practice, as well as how it can be a hindrance, potentially detrimental. Each of the participants is influenced by psychiatric diagnosis with all of them able to talk about some of the ways in which they are influenced. This included the feelings a psychiatric diagnosis may evoke within them, and possibly towards the client, as well as how it may influence whether they accept the patient. Interestingly, all participants discussed how the psychiatric

diagnosis influences the way in which they work with the client, which suggests that there is a specific method for 'treating' specific psychiatric disorders. The participants spoke about the relationship with the person who has made the diagnosis, who is often the person who has referred the client to them. The researcher felt some aspect of a power struggle emerged regarding this. Two of the participants indicated there was a difficulty in discussing diagnosis with psychiatrists, whereas one felt it was important to do so and believed it was not difficult to do. Jenny provided an insight into a possible power struggle within the divisions of psychology.

An important aspect emerged relating to which professional is 'allowed' to provide a client with a psychiatric diagnosis. Jenny states she often provides her clients with a psychiatric diagnosis, whereas Kathy states that, as a counselling psychologist, she is not allowed to do so.

4.4 Similarities & differences between the two groups

As discussed in the methodology chapter, the researcher could not identify a method for comparing findings from the analysis of two IPA studies. The researcher utilised his own method as outlined in the method chapter. This method concentrated on identifying similarities and differences between the two groups, looking back at the original transcripts to validate whether the differences were supported by the data, and discussing.

The cross reference table below presents the sub themes from the IPA findings for the psychotherapists and counselling psychologists. The table has then been cross referenced with sub themes from the comparing group. In order to complete this stage, within the method, the researcher utilised the ways of working from the stage 'Identifying connections across emergent themes' from the IPA method as discussed in the method chapter and as outlined in Smith (2009). The cross reference table, therefore, displays the sub themes that the researcher believes to be present for both groups.

Cross reference table (Table 3)

Themes from Psychotherapists		Data from Counselling Psychologist			
		Nicky	Ruby	Jenny	Kathy
<i>Superordinate theme</i>	<i>Subtheme</i>				
Wrestling with diagnosis	Useful aspects of diagnosis	P 6 L7 “It can give you a heads up, possibly a heads up”	P5 L23 “For some people it might feel quite a relief to have a label”	P1 L20 “think it gives them some sense of comfort and understanding of what it, is wrong”	P6 L19 “it’s a useful guide
	Diagnosis is a hindrance	P6 L12 “Sometimes work to undo the damage caused by a diagnosis”	P6 L27 “try and unhook the diagnostic label from their self-regard”	P1 L9-10 “I don’t have a problem with diagnosis erm, what I have a problem with is badly diagnosed people”	P6 L4 “people can get it wrong and I think sometimes we forget that”
Influence of diagnosis	Not accepting patients for treatment	P7 L15 “I don’t want to see narcissists I equally not prepared to see anyone with anti-social personality disorder”			
	Feelings evoked by diagnosis	P7 L15 “I don’t want to see narcissists	P10 L17-18 “I reeally like working with some, if somebody comes with a diagnosis of OCD”	P2 L13 “I like borderline patients”	P4 L16-17 “you do realise how manipulative some people can be in terms of their presentation and how they attend as its part of the

					game"
	Ways of working with clients	P 10 L23-24 "if you got someone with a diagnosis of bipolar disorder you might ultimately end up talking about the anxiety model but you would start with the bipolar model first because the bipolar stuff is the primary issue"	P1 L12-13 "the patient in the assessment might, might talk a lot more about anxiety and then my thoughts about the treatment plan will change"	P7 L18-19 "That's what I'm saying I don't know how we can talk about interventions without having an idea of what the diagnosis is I just don't get it"	P2 L10-11 "if you are working in a structured way you are thinking about case conceptualisation, formulation, treatment plan so all those things you are thinking about anyway but when you have a diagnosis to start"
Impact on formation of professional identity	Relationship between diagnosis and therapists experience and training			"Im a consultant counselling psychologist"	
	Impact of therapeutic setting	P4 L5-7 "on the nhs certainly it's not scope for people to spend years and years deciding whether or not they are willing to engage in therapy we have to provide a service to the community and we have to use those services responsibly"		P5 L22-23 "we are in this economic situation where there is pressure you know let's look at things like IAPT that are demanding a diagnosis etc"	
	In relation to	P7 L8-9	P9 L21 -23	P2 L22-23	P6 L15-16

	referrer	“a psychologist challenging a psychiatrist then you get into all sorts of power dynamics”	“what do you do with that you get somebody who erm trained and educated and experienced in how people work or the psychology and psychiatry and do on say that your per personality is disordered I just think that’s such a bleak prospect to live with and erm and its not the way I see people”	“the people I work mainly the people sent who people to me are people that I respect clinically so I don’t tend to have to many differences in regards to diagnosis”	“I feel ok it really depends on who they are and your relationship with them just like in anything but I think its ok it’s all about how you go about it really”
Responsibility	Responsibility and safety for therapist	P7 L15 “I don’t want to see narcissists I equally not prepared to see anyone with anti-social personality disorder”			
	Responsibility for patient		P6 L27 “try and unhook the diagnostic label from their self-regard” P9 L1 “think that for some people come wanting that label for a variety of reasons sometimes quite an unhelpful and unhealthy reason”	P8 L10-11 “the issue is around the more contentious diagnosis particular the personality disorders erm schizophrenia, bipolar because the implications particular in regards to driving”	P7 L11-12 “Yeah whereas people that may not have a diagnosis who may be you know equally distressed and struggling may not have access to a service because they don’t have a diagnosis so it can be a dangerous thing”
Importance of the therapeutic	Relationship is more important				

relationship	than diagnosis				
	Importance of the therapeutic alliance				
Themes from counselling psychologists		Data from Psychotherapists			
		Natalie	Linda	Alison	Lauren
<i>Superordinate theme</i>	<i>Subtheme</i>				
Wrestling with diagnosis	Useful aspects of diagnosis	P11 L5-6 "I think labels are necessary because it is a way of describing something"	P10 L23-24 "the different diagnosis and can help give some useful pointers and describe what's going on"	P6 L16-17 "kind of a diagnosis or they would say this person has been suffering with depression or anxiety"	P8 L17-18 "every industry has jargon even the psychotherapy industry has certain phrases and words"
	Diagnosis is a hindrance	P7 L6-7 "terminology are loosely, so loosely and so wide"	P9 L8-10 "Overt symptoms of acute OCD"	P4 L11-13 "there are different intensities and different levels"	P5 L18-25 "Case conferences, this is my view"
	Using diagnosis responsibly		P2 L7-8 "with that as the primary diagnosis I might suggest that they be better placed with another therapist"	P5 L11 -12 "I don't think it is necessarily the actual diagnosis I think it's treating everybody as completely unique and	P3 L15-17 "recently I have gone back to my notes almost to try and confirm to myself did I do I really still think that that patient was

				individual"	schizophrenic"
Influence of diagnosis	Direction of treatment	P1 L27 – P2 L1 "someone coming along with a neurotic illness I would be dealing with very differently to someone with a borderline"	P1 L10-11 "it does influence how I Initially start working with them, how I feel about them"	P13 L1-15 "I'm aware that you come with a diagnosis of depression"	
	Feelings evoked by diagnosis	P15 L14-15 "if they are coming from a psychiatrist what I do know is that they are going to be a very disturbed patient"	P7 L1 "my initial reaction is like oh my god you know for this person is completely nutty"	P10 L19-20 "no I actually quite like working with that level of intensity"	P8 L1 "certain words must be a trigger or must be a heart sink"
Political and economic implications	Relation to colleagues	P5 L23-24 "anyway I talked to my friendly psychiatrist [laughs]"	P5 L18 "there is some safety in that knowing a patient is already under the care of a consultant"	P10 L1-2 "she didn't speak very fondly actually of the psychiatrist side of our profession [laughs]"	P2 L25 -26 "I I would like to have an on going relationship with the psychiatrist"
	Economic pressure				

**Similarity & differences table
(Table 4)**

		Psychotherapists					Counselling Psychologists						
Superordinate	Subtheme	Natalie	Linda	Alison	Lauren	Total	Nicky	Ruby	Jenny	Kathy	Total	Comparison	Similarity (S) or difference (D)
Wrestling with diagnosis	Useful aspects of diagnosis	Y	Y	Y	Y	4	Y	Y	Y	Y	4	4/4	S
	Diagnosis is a hindrance	Y	Y	Y	Y	4	Y	Y	Y	Y	4	4/4	S
	Using diagnosis responsibly	N	Y	Y	Y	3	Y	Y	Y	Y	4	3/4	S
Influence of diagnosis	Not accepting patients for treatment	Y	Y	N	N	2	Y	N	N	N	1	2/1	N/A
	Ways of working with clients	Y	Y	Y	N	3	Y	Y	Y	Y	4	3/4	S
	Direction of treatment	Y	Y	Y	N	3	Y	Y	Y	Y	4	3/4	S
	Feelings evoked by diagnosis	Y	Y	Y	Y	4	Y	Y	Y	Y	4	4/4	S
Impact on formation of professional identity	Relationship between diagnosis and therapists experience and training	Y	Y	Y	Y	4	N	N	N	Y	1	4/1	D
	Impact of therapeutic setting	Y	Y	N	Y	3	Y	N	Y	N	2	3/2	S
	Relation to referrer	Y	Y	Y	Y	4	Y	Y	Y	Y	4	4/4	S
Responsibility	Responsibility and safety for therapist	Y	Y	N	N	2	Y	N	N	N	1	2/1	N/A
	Responsibility for patient	N	N	Y	Y	2	N	Y	Y	Y	3	2/3	S
Importance of the therapeutic	Relationship is more important than diagnosis	Y	Y	N	N	2	N	N	N	N	0	2/0	D

relationship	Importance of therapeutic alliance	N	N	Y	Y	2	N	N	N	N	0	2/0	D
Political and economic implications	Relation to colleagues	Y	Y	Y	Y	4	Y	Y	Y	Y	4	4/4	S
	Economic pressure	N	N	N	N	0	Y	Y	Y	Y	4	0/3	D

The similarity and differences table displays which participants, according to the IPA master tables, spoke about each sub theme. The table also shows the number of psychotherapists and counselling psychologists who spoke about each sub theme. The researcher chose to define a similarity between the two groups as greater than 50 percent of the participants who spoke about the sub themes. Potential differences were defined as appearing in the table for one group and for less than 25 percent for the other. The similarities and differences identified in the above table were then explored in relation to the original texts to see if this was supported by the raw data. This is now discussed:

The similarity and differences table suggests there are ten potential similarities and four potential differences between the two groups identified through the analysis of the IPA findings. These findings are now analysed further, with reference to the original data, in order to look for evidence that supports or contradicts the sub themes being classed as similarities or differences.

4.4.3 Similarities

The highlighted similarities from the table are now explored further looking at the possible relationship between the two groups.

- **Wrestling with diagnosis**

All participants were able to discuss the useful aspects of psychiatric diagnosis as well as how they believe it to be a hindrance. Three of the four psychotherapists and all the counselling psychologists spoke about the importance of using psychiatric

diagnosis responsibly. These three sub themes all came under the superordinate theme of ‘wrestling with diagnosis’ therefore, the table indicates this is the most prominent similarity between the groups.

Psychotherapist Natalie was able to express how she feels labels are necessary and that it helps to describe something (Natalie P11 L5-6). Natalie’s view appeared to be echoed by counselling psychologist Kathy, where she states :

“It is a useful guide” (Kathy, P6, L19).

Psychotherapist Linda was able to explain that diagnosis can help describe what is going on (Linda P10 L23-24) and this appeared to sound similar to the words of counselling psychologist Ruby:

“give me some kind of preparation as erm the sort I might expect from seeing the patient for the first time” (Ruby P1 L5-6) and counselling psychologist Kathy states *“somebody has already had an opportunity to give their opinion on the situation” (Kathy, P6, L19).*

In relation to how the entire group was able to express a view that psychiatric diagnosis can be seen as a hindrance, the group were all able to express some negative aspects, however, the examples seemed to be different between the two groups, with the psychotherapists describing how loose psychiatric diagnosis can be. Natalie stating that:

“terminology are loosely, so loosely and so wide” (Natalie, P7, L6-11).

Linda stating:

“overt symptoms of acute OCD” (Linda, P9, L8-10).

Alison stating:

“There are different intensities and different levels” (Alison, P4, L11 -13).

Lauren expressing a view that case conferences provide a better forum to discuss client material instead of summarising into the wording of a diagnosis.:

“Case conferences, this is my view” (Lauren, P5, L18-25).

The counselling psychologists appeared to be more concerned with the damage psychiatric diagnosis can do to clients:

“sometimes work to undo the damage caused by a diagnosis” (Nicky, P6, L12).

Ruby stating:

“try and unhook the diagnostic label from their self regard” (Ruby, P6, L27).

They were also concerned with the fact human beings make a diagnosis, which means it could be erroneous:

“I don’t have a problem with diagnosis erm, what I have a problem with is badly diagnosed people” (Jenny, P1, L9-10)

Kathy backs this up:

“people get it wrong and I think sometimes we forget that” (Kathy, P6, L4).

Therefore, we can see that upon discussing how diagnosis can be a hindrance as a similarity between the two groups, we can also see how there are some differences within that.

- **Ways of working with clients & direction of treatment**

The similarities and differences table shows three out of four of the psychotherapists and all the counselling psychologists provided data to indicate they are influenced by the presence of a psychiatric diagnosis. These participants all showed that the direction of the treatment is influenced by the diagnosis. For example, psychotherapist Linda states:

“It does influence how I initially start working with them, how I feel about them” (Linda, P1, L10-11).

This suggests that the way in which she works is influenced by the diagnosis.

Psychotherapist Natalie also expresses a similar view:

“someone coming along with a neurotic illness I would be dealing with very differently to someone with a borderline” (Natalie, P8, L1).

All the counselling psychologists were able to discuss the fact that the way they work is dependent on the diagnosis. Ruby states:

“the patient in the assessment might, might, talk a lot more about anxiety and then my thoughts about the treatment plan will change” (Ruby, P1, L12-13),

Nicky explained:

“if you got someone with a diagnosis of bipolar disorder you might ultimately end up talking about the anxiety model but you would start with the bipolar model first” (Nicky, P10, L23-24).

Once again, there appears to be some level of discrepancy between this similarity, in the fact that the counselling psychologists overtly express the view that the way they work will be specifically linked to the diagnosis, whereas the psychotherapists seem to be saying the same thing, however, do not appear forthcoming in saying so or not aware that they do.

- **Feelings evoked by diagnosis**

All participants were able to speak about the fact that psychiatric diagnosis evokes specific feelings within them. For example psychologists Ruby (P10, L17-18):

“I really like working some, if somebody comes with a diagnosis of OCD”

Jenny (P2, L13):

“I like borderline patients”.

Psychotherapist Linda (P7, L1) stating:

“my initial reaction is like oh my god you know for this person is completely nutty”.

And psychotherapist Lauren (P8, L1) expressing her opinion:

“certain words must be a trigger or must be a heart sink”.

- **Impact of therapeutic setting**

Three of the four psychotherapists and two of the counselling psychologists spoke about how the impact of the therapeutic setting influences the way they work with specific psychiatric diagnoses. Psychotherapist Natalie (P1, L16-17) states:

“there are certain diagnoses that actually wouldn’t work in private practice would not be suitable at all”.

And psychotherapist Lauren (P5, L1-3) declared:

“think that one of the many benefits that I had had from working at the hospital is the fact that my, I suppose, exposure to medical terminology erm diagnostic tools and diagnostic thinking”.

The counselling psychologists also spoke regarding the setting, however, it appears to be in a different light. Jenny (P5, L22-23) stating:

“we are in this economic situation where there is pressure you know lets look at things like IAPT that are demanding a diagnosis etc.”.

At first glance, the researcher felt this sub theme was a similarity, however, when attempting to unpick what is meant, major differences seem to emerge. Jenny is speaking about the therapeutic setting being IAPT inside the NHS, as opposed to a setting as a tangible building or place. Nicky (P4 L5-7) also speaks about the NHS in relation to diagnosis. This opens up a potential difference with regard to whether more counselling psychologists have worked within the NHS than psychotherapists, and how this may influence the findings. If the psychotherapist participants have only worked within the private sector, then their lived experiences will not include any aspect of the NHS. If the counselling psychologists have all worked within the NHS at some point, then their lived experiences will also include their time in the NHS, regardless of whether the interview was only concerned with the private sector. This highlights the difficulty and, perhaps, impossibility of being able to bracket out specific aspects of experience.

Half the psychotherapists and three quarters of the counselling psychologists spoke about the responsibility for the patients in relation to psychiatric diagnosis. Linda, one of the psychotherapists stated:

“with that as the primary diagnosis I might suggest that they may be better placed with another therapist” (Linda, P2, L7-8).

This, perhaps, is open to interpretation as to whether Linda is putting herself first, or the client, as she possibly does not want to work with someone who comes with a specific diagnosis. From the counselling psychology group, Ruby (P9, L1) spoke on the topic of patients desiring a diagnosis for reasons that are unhealthy to them;

“Think that for some patients come wanting that label for a variety of reasons sometimes quite an unhelpful and unhealthy reason”.

This suggests that, if she is aware of this situation arising, she needs to be responsible as how she uses, and refers to the diagnosis. For Jenny (P8, L10-11) the responsibility for the patient and, possibly, to other people, is apparent when she states:

“the issue is around the more contentious diagnosis particular the personality disorders erm schizophrenia, bipolar because the implications particular in regards to driving”.

Here, Jenny may be considering the responsibility as to possible ramifications for a patient if she diagnoses them with schizophrenia or bipolar, for example they may have to surrender their driving license. Jenny, perhaps, may be considering the responsibility towards external people in relation to how a patient's diagnosis could impact upon them.

- **Relation to colleagues & referrer**

The final similarity which emerged from the table is in regard to the relationship with colleagues, and to the person referring a patient. All the participants were able to speak about the implications of this relationship and how it can influence the way they work with psychiatric diagnosis. Two of the counselling psychologists spoke about a possible power struggle; Nicky (P7, L8-9) spoke the words:

“a psychologist challenging a psychiatrist then you get into all sorts of power dynamics”.

Nicky may be suggesting she feels unable to say to a psychiatrist that she disagrees with a psychiatric diagnosis, which may show how the relationship to the referrer influences the way in which she views, or works with, the diagnosis provided. Linda (P5, L18) feels more comfortable knowing the patient is also seeing a psychiatrist, she stated:

“There is some safety in that knowing a patient is already under the care of a consultant [psychiatrist]”.

Linda may be demonstrating that she has the courage to work with a patient with a specific diagnosis because the patient is under the care of a psychiatrist. In the case of Alison, she stated:

“she didn’t speak very fondly actually of the psychiatrist side of our profession [laughs].”(Alison, P10, L1-2).

The researcher interpreted her laugh as to be in agreement with the patient’s view of psychiatry. If the researcher’s interpretation is accurate then this would suggest the way in which she would view psychiatric diagnosis. The three examples show how the participant’s relationship with colleagues and referrers may influence the way they work with the psychiatric diagnosis.

4.4.4 Differences

The four potential differences will now be explored in relation to the participant’s data in order to qualify whether they can be classed as differences or not.

- **Relationship between diagnosis and therapists’ experience and training.**

This subtheme emerged for all the psychotherapists, however only one counselling psychologist, Kathy, appeared to discuss this. Revisiting the data, in relation to this potential difference, provided a statement from Ruby which also seemed to fit:

“you know just in terms of counselling psychology it’s not the focus isn’t diagnosis it isn’t labelling people” (Ruby P3, L9 – 10).

Ruby is demonstrating how she believes that, possibly, the theoretical underpinnings of counselling psychology are to ensure psychiatric diagnosis is not the focus of the work, and it does not agree with labelling people. Ruby is speaking as if she is a spokesperson for counselling psychology. Jenny’s statement that she is a consultant psychologist led the researcher to look back at her data, in search of other ways in which she may also fit into this subtheme. In relation to training, Jenny states:

I think the downside of counselling psychology is a naivety not to actually set a lot of counselling psychologists up to have a language of the mental health world
(Jenny P5, L17-18).

In relation to experience, she informs the researcher that she has held positions including:

“head of older adult psychology and neuropsychology” (Jenny P10, L13-14).

The researcher wondered whether this has had more of an impact upon her opinion on the usefulness of psychiatric diagnosis than he had originally thought when completing the IPA study consisting of counselling psychologist.

Jenny also spoke about the training she feels counselling psychologists receive, and stated:

“they kind of come out of training and they are like you know ducks out of water they just don’t know what to do they are flapping around because err you know I can give them a patient and I know they will be really good at actually working with the patient because I know how they have trained in regards to assessment giving a working diagnosis you know what it feels like it could take a long time” (Jenny, P5 L19-22).

Jenny is showing how she believes once counselling psychologists finish training, they are out of their depth with regard to providing a psychiatric diagnosis. This provides an interesting perspective on how Jenny perceived the training counselling psychologists receive. It is also interesting that Jenny is a counselling psychologist and alludes to the fact that she understands they will be very good in working with the patient, however, she feels, perhaps because she once felt the same way, that identifying a diagnosis to work with, is not easy for them. The choice of analogy is interesting, she refers to the newly trained counselling psychologists as ‘ducks out of water’ and that they are ‘flapping around’ just like a duck may, if out of its milieu. Once more, the researcher felt that Jenny could be speaking about how she felt as a newly qualified counselling psychologist. The last part of the paragraph is of interest, as she infers that if she is asking a counselling psychologist for a working diagnosis

she ‘feels like it could take a long time’. The researcher wondered if she may also be describing that she felt it took a long time to adapt from her training where she, possibly, felt like a duck out of water and was flapping, with regard to psychiatric diagnosis. Attempting to interpret this paragraph, the researcher wondered if Jenny was angry towards her training, and looking back at the data, identified another passage that appeared to be important:

“I loved my training I chose to do counselling psychology I didn’t do counselling psychology because I couldn’t get onto clinical psychology” (Jenny, P10, L6-7).

This sentence was spoken three quarters of the way through the interview and after the paragraph regarding newly trained counselling psychologists as ‘ducks out of water’. The researcher found this sentence of particular interest in respect to the word ‘loved’, which is a stronger word than liked or enjoyed, she is stating how she loved her training. She then continues to tell the researcher that she chose to do counselling psychology, and wanted to make it clear it was not her second choice, the first being a clinical psychology training course. The researcher wondered whether she had ended up doing counselling psychology because she had not been able to get onto a clinical course, or perhaps she is angry that she feels she made the wrong choice and regrets not choosing the clinical training. The latter interpretation felt plausible due to the fact she used the term ‘I loved my training’ possibly as a defence to help her not think about the possibility that she regrets her choice. Now that the researcher had a feeling Jenny regretted her training as a counselling psychologist he revisited the data once more, looking for more information to support this, and found another interesting passage regarding training:

“if someone says they believe in counselling psychology you sort of I don’t know you give up some your ethical sense disappears or your true understanding of the psyche of the person goes if you use a diagnosis and I just think that’s naïve I think there is a way of offering this diagnosis actually given there is so much more to it” (Jenny, P10, L27-29).

Jenny is showing how she perceives the counselling psychology training’s position on psychiatric diagnosis. Jenny is also showing how she feels someone who believes in counselling psychology would sacrifice an aspect of their ethical being if you start to use psychiatric diagnostic terminology. She also explains how, perhaps, by doing so, you no longer understand the ‘psyche of the person’. The researcher believes this is possibly the way Jenny felt following the completion of her training. He believes that she felt like a duck out of water, flapping around trying to work with diagnosis, and that it took her a long time to be able to change the way she thought about diagnosis. When she was able to change her mind-set she felt she was going against her training and found it an ethical dilemma for her. This, in turn, left Jenny possibly believing she no longer understood the psyche of people. Jenny goes on to say how she was able to find a way in which she was able to work with diagnosis that no longer left her with a sense of abandoning her ethics or her training. It also enabled the researcher to wonder whether she is angry towards the training, that it had left her with a certain perspective on psychiatric diagnosis that, for her, did not seem to fit well with the work she was doing upon leaving the training.

Finding that Ruby and Jenny spoke about the connection between diagnosis and the therapists experience and training, indicated this sub theme could not be classed as a difference and in fact may be more akin to being a similarity.

- **The importance of the therapeutic relationship**

From the subthemes two of the psychotherapists spoke about how the ‘therapeutic relationship is more important than a diagnosis’ whereas none of the counselling psychologists appeared to do so. The same was true for the sub theme of ‘the importance of the therapeutic relationship’. This suggested that the superordinate theme of ‘the importance of the therapeutic relationship’ was significant for the psychotherapists and not for the counselling psychologists. Upon revisiting the data, the researcher uncovered that this was present, and of significant importance, for one of the counselling psychologists.

“some people ask me what’s my orientation, my orientation is the therapeutic relationship every single time forget all the other theories, quite frankly we spend too much time saying this that and the other is wonderful when really it is about the therapeutic relationship” (Jenny, P3, L12-14).

Jenny is showing how she places the most importance upon the therapeutic relationship. This reminded the researcher of the psychotherapist Linda’s words:

“What all I need to remember is it’s about the relationship and how we’re able to meet somebody” (Linda, P8, L1-2).

The fact the researcher was only able to identify one counselling psychologist who mentioned the therapeutic relationship during the interviews led the researcher to classify this as one of the differences.

- **Economic pressure**

Three out of the four counselling psychologists spoke about the economic pressures that can have an impact upon the use of views of psychiatric diagnosis. This did not emerge in any sub theme for the psychotherapists. The researcher could not identify any relation to economic pressure within the data for the psychotherapists.

Therefore, this was classed as one of the differences.

4.4. 5 Conclusion of the findings from the comparison study

After completing the tables based upon the findings from the two group's IPA master tables, and through revisiting the original transcripts the similarities and between the two groups are listed below:

Similarities

- A majority in each group were able to speak about the usefulness and disadvantages of psychiatric diagnosis
- Both groups believe that diagnosis needs to be used responsibly

- The way both groups work is influenced by the presence of psychiatric diagnosis
- Psychiatric diagnosis evokes feelings within all the participants in both groups
- The relationship with colleagues and the person referring can affect or be affected by the psychiatric diagnosis
- For both psychotherapists and counselling psychologists there is a relationship between diagnosis and therapists' experience and training

Differences

- The psychotherapists put more emphasis on the therapeutic relationship than the counselling psychologists
- The counselling psychologists spoke about the economic pressures which influence the use of psychiatric diagnosis, whereas the psychotherapists did not.

The researcher was interested in whether what emerged for one group may also emerge for another. The method adapted by the researcher enabled this to be explored. The method was able to identify similarities and differences between the two groups based on the findings of the two IPA studies. There appeared to be more similarities than differences, however did not provide a strong rationale as to why.

4.5 Conclusion of findings chapter

This chapter presented the findings from two separate IPA studies. Both studies asked the same question to two different groups of participants. The first group consisted of psychotherapists and the second group of counselling psychologists.

The data was analysed using IPA as the research method, as outlined in the previous chapter. A number of findings emerged for both groups and the findings in relation to the research question will be explored further in the discussion chapter.

The study was also concerned with whether the findings from one group may emerge when the same question was asked to a different group. The researcher therefore completed a study looking at the findings of both studies in order to identify possible similarities and differences between the two groups. There appeared to be more similarities than differences which have been discussed. The researcher believes IPA had enabled a comparison to be completed, however there appears to be significant limitations to the method that he used which may have influenced the findings. These are discussed later.

5. DISCUSSION

This chapter aims to discuss the findings from the two IPA studies and also from the comparison study, in relation to the research question “In what ways, if any, does psychiatric diagnosis influence the way psychotherapists and counselling psychologists work?” The chapter also explores these findings in relation to the literature review.

The discussion chapter continues to explore the use of IPA to conduct the two studies and the benefits and limitations of using the findings from the two IPA studies to conduct the comparison study. The researcher considers possible further studies building upon this study. Finally, there is an exploration as to the researcher’s own motivations for conducting this study and how this may have contributed to the findings.

5.1 Discussion of Findings

The study highlights a number of important findings in relation to the psychotherapists and counselling psychologists interviewed, and the ways in which psychiatric diagnosis influences the manner in which they work.

5.1.1 Wrestling with diagnosis

The study found that all participants, from both groups, were able to talk through the possible benefits, as well as the disadvantages of the use of psychiatric diagnosis within their practice. There seemed to be more being spoken about than simply the

benefits and disadvantages, there appeared to be a struggle that was present. Many of the participants contradicted themselves, for example, psychotherapist Alison, on several occasions, stated she is confident that psychiatric diagnosis does not influence her work, however, later on (Alison P 11 L13-18) informed the researcher that if someone comes with a psychiatric diagnosis of depression she would commence the session by referring to the diagnosis. Counselling psychologist Jenny seemed more aware of the struggle, as she had informed the researcher she would use the psychiatric diagnosis provided to identify a treatment plan, however, she also explains that she will ignore anyone else's diagnosis that has been provided (Jenny, P2, L14-15). The above struggle which emerged was of particular interest, as the literature review highlighted a number of authors who were in favour of using psychiatric diagnosis (Thorne, 1945; Macaskill, 1999; Ghaffari, 2004). The literature review also provided a number of those against (Rogers, 1946; Cooper, 2005; Corey, 2005; Boyle, 2007; Cox, 2010) and those who appeared to take a middle ground (Jackson, 2012; Cradock, 2012; Roudinesco, 2001). Therefore, the literature on the topic of psychiatric diagnosis, perhaps, could be seen to provide a confusing approach to its use, which could add to the confusion for the participants. Another possible rationale for the above struggle, perhaps, is related to how they view the word 'diagnosis'. The literature review quoted the two different uses of the word 'diagnosis' as defined by the Oxford English Dictionary (2010):

1. The identification of the nature of an illness or other problem by examination of the symptoms.
2. The distinctive characterisation in precise terms of a genus, species, or phenomenon.

The researcher questions whether the participants' use of the word 'diagnosis' was shifting between these two meanings. For the majority of the time it would be towards the first definition, however, it appeared, sporadically, the second definition possibly was emerging. The researcher wonders whether this is because the first definition is the dominant discourse, and a more positivistic way of looking at the world, with the second being the more hermeneutic way, concerned with people's experiences. Perhaps the participants' use of the word diagnosis was shifting between these two definitions depending on the context, therefore creating confusion for them and possibly for the researcher. One example being for Natalie, she often spoke about psychiatric diagnosis as more closely related to first definition; not accepting patients based on their diagnosis (Natalie P1, L15-17, P5, L1-2) and stating patients who are referred from a psychiatrist are going to be very disturbed (Natalie P15, L14-15). However, later in the interview when speaking about labelling, which the researcher believes Natalie is including psychiatric diagnosis as a contributing factor, she appears to be more aligned to the second definition from the Oxford English Dictionary, she stated:

“Under all that labelling there's a human being with some serious problems you know so erm we human beings aren't all that different really! Erm [laughs] and it just depends on what has happened to people you know” (Natalie, P10, L13-16).

The researcher questions whether it was easier for Natalie to see the word 'labelling' from a more hermeneutic stand point than the word 'diagnosis'. This shift in meaning regarding words like 'diagnosis' and labelling' may indicate a shift in the

way that Natalie views the world; predominantly through a positivistic lens, though, on occasion the more hermeneutic way emerges.

5.1.2 Using psychiatric diagnosis responsibly

In addition to being able to speak about the potential benefits and disadvantages of psychiatric diagnosis, the majority of the participants also described how psychiatric diagnosis needs to be used responsibly. The most obvious was the way the clinician needs to be responsible for the safety of the patient and themselves. However, the researcher questioned whether this was ever in the patient's best interest. Natalie spoke about how she would make specific arrangements for her personal safety based upon a diagnosis. Linda stated that she would feel a patient was better placed with a different therapist based upon their diagnosis. The aforementioned examples show how they have not been seeing the patient for who he or she is, but as the label of their diagnosis.

There are other aspects to how the responsibility of psychiatric diagnosis may influence the way the participants work. Kathy explaining how a diagnosis can open up funding for other services thus showing how her work is, perhaps, influenced, as she could make a referral to those additional services or may bring them up during therapy. An important way is also mentioned in respect to how psychiatric diagnosis can impact upon a patient's civil liberties; Jenny (P8, L11) spoke about the implications the diagnosis of personality disorder, bipolar disorder and schizophrenia have upon the permission to drive a vehicle. Jenny did not elaborate upon this,

therefore from reading the UK Government website regarding bi-polar disorder the researcher found that it states:

“You can be fined up to £1,000 if you don’t tell DVLA about a medical condition that affects your driving. You may be prosecuted if you’re involved in an accident as a result” (Gov.uk 2014).

This reminded the researcher as to Spitzer *et al* (1973)’s words regarding people’s civil rights becoming denied based upon a mental illness. As Jenny had expressed that she often provides a psychiatric diagnosis for her patients, by speaking about the possible implications specific diagnosis can bring, Jenny could be showing how she may be influenced not to provide a diagnosis. Even though this is not specifically showing how her work is influenced by psychiatric diagnosis, it raises an important point as to what other factors may be at play when someone is considering making a psychiatric diagnosis. According to Boyle (2007:9) there is no evidence that schizophrenia is a brain disease and according to Spitzer (in Davies 2013) most disorders in the DSM do not have a biological cause, yet Jenny is possibly providing a factor that is taken into account when making a diagnosis. The researcher acknowledges that it is not always clear as to who the participants are being responsible to, and whether it is always ethical responsibility towards their client or not.

It is also interesting to note that the UK Government has listed psychiatric disorders under medical conditions. This may also add to the struggle that has been discussed

above, as diagnosis now has another dimension, in that diagnosis is, here, is always related to the medical model which the Oxford English Dictionary does not state.

5.1.3 Cannot escape influence

The findings of the study show that all the participants, to some extent, are influenced by the presence of a psychiatric diagnosis, even when they believed they are not influenced. This seemed to hint at a possible answer to how Boyle (2007) was looking at the reasons why diagnostic labelling is still being used; perhaps in today's society it is extremely difficult to escape the diagnostic terminology.

Psychotherapist Lauren stating that “every industry has jargon even the psychotherapy industry has certain phrases and words” (Lauren P8, L18-19) which helps to show that, perhaps, diagnostic language is a major discourse in the UK today. Counselling psychologist Jenny goes further to show how it is necessary to use this terminology if you cannot escape from it, where she states “the counselling psychologist staff struggled in communicating with psychiatrists and the rest of the teams because they came from this protected sense of not stigmatising someone” (Jenny P10, L23-24). This was in line with Dudley's (2004) words where she explains that she tries to not use diagnostic terminology and fails every single day and stated “I am aware of my wish to belong, to feel connected to the main influential group and to experience the power and connection that such belonging gives” (Dudley 2004: 14). Therefore, working within the field of psychotherapy and counselling psychology, one may not be able to escape the use of diagnostic terminology, and also there can be a desire to be accepted and to be part of the work

place, and fit in with already established colleagues. This leads therapists to perhaps consider the setting in which they chose to work from.

5.1.4 Direction of treatment / Ways of working

An interesting finding emerged in that all the counselling psychologists were able to speak about the fact the direction of the treatment was dependent upon the psychiatric diagnosis. If they received a referral letter with a psychiatric diagnosis provided, prior to being seen, all the counselling psychologists would have an idea of how they would work with the patient. The counselling psychologists were able to explain a reason for this, in that there appears to be a set way of working with each disorder or “treatment plan” (Jenny P7, L23; Ruby P1, L13 Kathy P2, L10). The psychotherapists were also influenced in a similar manner but did not speak about it overtly. Natalie (P1, L27 – P2, L1) explaining how she would commence working with someone differently if they came with a neurotic illness as opposed to a borderline personality disorder and Alison (P13, L14-15) expressing the fact that if she has a referral stating someone has a diagnosis of depression she will commence the session referring to the depression. Upon completion of the two IPA studies, the researcher believed there was no connection between the treatment plan as described by the counselling psychologists and how the psychotherapist’s way of working was influenced. However, upon attempting to conduct a comparison of the two sets of findings, the researcher felt that these were more connected than initially appeared. The researcher hypothesises, perhaps the counselling psychologists’ training teaches ‘treatment plans’ which are dependent on the psychiatric diagnosis, whereas

psychotherapy training does not. However, the study suggests that some of the psychotherapists are also doing this, perhaps just not aware of the fact.

5.1.5 Refusing Patients

Two of the four psychotherapists and one of the four counselling psychologists described how they would not accept patients based upon their diagnosis. Nicky (P7, L15) stating she would not see patients diagnosed with anti-social personality disorder, and Linda (P8, L14-16) describing the way that she would refuse a patient based on the diagnosis; she would explain to the referrer that she does not have space to see the patient. This opens up an interesting conversation as to who will see the people that have been turned away for therapy. Another important realisation for the researcher was how this could impact the patients who have been refused therapy. A rejection from a psychotherapist or counselling psychologist could possibly cause more psychological damage. This connects to specific aspects of labelling theory, and perhaps could be seen as one of the secondary deviances of being labelled, with a psychiatric diagnosis that Scheff (1966) wrote about. For example, the diagnosis that Nicky stated she would not be prepared to work with is anti-social personality disorder (or F60.2 as classified in the ICD-10, or 301.7 as classified in the DSM). The National Institute for Health and Care Excellence (NICE) describes the condition as:

“Antisocial personality disorder is the name given to a condition that affects a person's thoughts, emotions and behaviour. Antisocial means

behaving in a way that is disruptive to, and may be harmful to, other people.” (NICE 2009)

The definition provided describes an antisocial personality disorder as a condition which affects thoughts, emotions and behaviour. The researcher questions whether a patient labelled as such, and then rejected by a therapist for help with their thoughts, emotions and behaviour could perhaps reinforce the thoughts, emotions and behaviour, which they have been struggling with. This could result in the patient becoming more disruptive and possibly lead them to cause harm to others, strengthening the position that they are suffering from an antisocial personality disorder. Refusing patients based upon their diagnosis, once more, highlights how some of the participants were not seeing a patient as a person rather than a label, possibly using psychiatric diagnosis as a tool to decide whether to see people or not.

5.1.6 Training and experience

The clinician’s training appears to influence the way in which they work with diagnosis. Jenny provided an insight into how the training she received, as a counselling psychologist, influenced the way in which she initially worked with diagnosis. She referred to newly qualified counselling psychologists as “ducks out of water” (Jenny, P5, L19) when it came to identifying diagnoses, the researcher believes that is perhaps how she felt at that time. According to Alison, the psychotherapeutic model of person centred psychotherapy does not “do diagnosis, don’t do assessments” (Alison, P11, L25). However, Alison, in the same paragraph,

continued to state that she had been on courses since completing her core training on the topic of assessments. This suggests that the training which both Jenny and Alison received left areas in which they desired to develop themselves, even if this meant going against some of their beliefs of the initial training. Once more, revealing a struggle with the way they perceive psychiatric diagnosis. It is not clear as to precisely why these two clinicians, from different disciplines, appear to change their viewpoint regarding psychiatric diagnosis through their experience. Jenny does offer a strong insight, where she spoke about how counselling psychologists (Jenny P10, L23-24) struggle to communicate with psychiatrists and other members of the team. This could, perhaps, mean that, in order to be able to fit in and to communicate better with other team members, they needed to have a different viewpoint on psychiatric diagnosis. This echoed the words of Parker (1995) where he explained that psychotherapists face a moral and political choice, as to where their allegiances lie, in relation to diagnosis. It also reiterated the point which Dudley (2004) makes, where she describes her longing to feel connected to the most influential group within her work, and how this means she uses diagnostic terminology everyday, even though she fights against doing so.

In addition to the way in which Alison and Jenny's viewpoint was influenced by their continuing experiences, psychotherapist Lauren also provided an interesting perspective. She spoke about the way she was able to challenge a diagnosis provided by a psychiatrist, and explained that she was only able to do so, because of her experience (Lauren, P2, L8-11). She also described how her learning experience had changed the way she felt about a diagnosis and used the phrase "not be so in awe of that moment, that letter, that diagnosis" (Lauren, P5, L25-26). The participant's

words regarding training and experience added to the position that, perhaps, a person's viewpoint of how they work with psychiatric diagnosis, is always evolving.

5.1.7 Direction of treatment

The study suggests that the direction of treatment for all the participants was influenced by the psychiatric diagnosis. It is of interest that the counselling psychologists were forthcoming in this respect whereas the psychotherapists did not implicitly state this; however the data suggested that they were influenced. The data suggests that the training of a counselling psychologist may teach this, which is a possible rationale as to why they were able to overtly say the direction of treatment is dependent upon the diagnosis. The data did not suggest that the psychotherapists' training would teach them to use a psychiatric diagnosis to dictate the way they work. In fact, the training of the researcher, as a psychotherapist, suggests that the opposite would be true. Therefore, it is of interest that all the psychotherapist participants were influenced in the way that they worked based on the psychiatric diagnosis. This suggests a less phenomenological way of working than the researcher may have hypothesised would emerge from the study.

5.1.8 Economic pressure

The study highlighted that three of the counselling psychologists spoke about the economic pressures which influence the use, or views regarding psychiatric diagnosis, whereas none of the psychotherapists spoke on this topic. Kathy's words regarding insurance companies and how they will fund the cost of treatments for specific disorders and not others, suggests how Craddock's critique of the USA's approach to diagnosis may be the same in the UK. "In the US, if a professional wants to help someone, they need to label the problem as something that justifies giving the help" (Craddock as cited in Jackson 2012). Once more this can show how clinicians come face to face with the moral and political dilemma which Parker (1995) spoke about. Kathy is demonstrating how a clinician can determine whether somebody receives treatment or not. The dilemma, however, appears to be more complicated than simply stating someone has a specific diagnosis, or has symptoms of a diagnosis, in order to receive funding. Kathy and the other participants are aware of the negative connotations associated with psychiatric diagnosis, therefore, by informing an insurance company that someone has a diagnosis when they do not, can have further implications. This situation opens up the conversation surrounding how funding of mental health can be abused. Kathy also provides an understanding as to how specific services are only open to people who have been diagnosed with specific disorders and, how, as a clinician, there is pressure, whether it is internal or external, to diagnose somebody with the purpose of being able to access those services. This reminded the researcher as to the study (Douglas, Toffalo and Pedersen 2005), which highlighted school psychologists basing their recommendations for specialist education more so on psychiatric diagnosis than any other fact, which went against the guidelines. This finding empathises the way psychiatric diagnosis can help access specific services which have been designed for that disorder. It also suggests that

providing an erroneous diagnosis can allow access to these services. This indicates, once more, that psychiatric diagnosis can be abused in order to facilitate a different agenda than the one for which it is designed.

Interestingly, none of the psychotherapists mentioned the economic pressures, this has been discussed previously, however, the researcher wondered whether Natalie's words could also provide further insight into this. Natalie spoke about how, when she did her training, she would not be expected to see anyone who was suicidal; however she feels that is now the "norm" (Natalie, P8, L24-25). This may indicate a shift in the public's mental health or wellbeing. Natalie, perhaps, is inferring that there are more suicidal people today than when she trained and, therefore, there is a greater need for psychotherapy, which in turn means there is more of an economic pressure to provide the needed therapy. The researcher acknowledges that Natalie may instead be referring to a change in training; however, felt the former interpretation was more likely.

5.1.9 The therapeutic relationship

The findings highlighted that all the psychotherapists spoke about the therapeutic relationship either in the context of how important they believe it to be, or that they believe it is more important than a psychiatric diagnosis. Only one of the counselling psychologists, Jenny, mentioned or alluded to the importance of the therapeutic relationship. The BPS in their Practice Guidelines (2006) state how counselling psychology has "a value base grounded in the primacy of the counselling or

psychotherapeutic relationship” which led the researcher to be curious as to why only one of the counselling psychologists referred to it. It is of further interest that the only counselling psychologist who did make reference to the relationship was Jenny, who appears to have distanced herself further from her training than her colleagues, in relation to her viewpoint on psychiatric diagnosis.

The researcher did not ask about the therapeutic relationship, therefore, the fact that all the psychotherapists made reference to its importance implies that perhaps it is what is really important within their work. This appears to relate to the literature found where Rogers (1951), Arbuckle (1961) and Sanders (1974) indicate that diagnosis can obstruct the usefulness of the therapeutic relationship (for example, seeing the person based upon a label instead of the person behind the label).

5.1.10 Who can make a psychiatric diagnosis?

The findings from the counselling psychologists provided a further interesting and important possible rationale as to the struggle that had not been identified within the literature. This rationale only became apparent through two participants’ interviews and, due to selecting a phenomenological method for the study, allowed this to emerge. Counselling psychologist Jenny stated, on a number of occasions, that she provides a psychiatric diagnosis for her clients (Jenny P1,L18; P12, L11-12). This shows how psychiatric diagnosis influences her work as she is perhaps looking to make a diagnosis if one is not provided. Ruby, however, stated that she is not

allowed to make a psychiatric diagnosis (Ruby P8, L1-2). This opened up the conversation as to who is, and who is not, allowed to make a psychiatric diagnosis. The researcher chose to contact the British Psychological Society (BPS) and the British Association for Counselling & Psychotherapy (BACP) and ask the question as to who is allowed to make a psychiatric diagnosis. The response from the BACP was that psychotherapists and counsellors cannot make a psychiatric diagnosis and referred me to the Royal College of Psychiatry (RCP) (see appendix 6). The researcher interpreted this response as the BACP would be willing to accept the RCP's viewpoint. The researcher had already contacted the RCP and their registrar prepared a statement (see appendix 7) for the researcher which stated:

"It is the position of the Royal College of Psychiatrists that a diagnosis should only be made after a thorough assessment of the physical, psychological and social issues facing the patient. The training of psychiatrists equips them to make a diagnosis. Patients expect diagnoses to be made by experienced professionals who have a knowledge of all the areas outlined above. I am not an expert in the training of other professionals and so cannot comment on whether their training fully equips them in these areas." (Conlon 2014)

The researcher found it of particular interest that their Registrar, Dr Mynors-Wallis, refers to 'diagnosis' as opposed to 'psychiatric diagnosis'. This could be for a specific reason, for example, making sure his comments are not only related to psychiatric diagnosis, or perhaps Mynors-Wallis does not use the term psychiatric

diagnosis as often as the term diagnosis. The researcher did not feel comfortable to make an interpretation either way and has chosen for the reader to make their own interpretation as to this. Mynors-Wallis uses the word “should” when he states “...a diagnosis should only be made after...”, It is of interest to the researcher as to why he uses the word ‘should’ as opposed to ‘can’. The word ‘should’ implies, to the researcher, that it is possible for a ‘diagnosis’ to be made without the conditions, which he continues to mention, but perhaps the RCP does not approve of this. If he had used the word ‘can’ in place of ‘should’ it would indicate that the position of the RCP is that a ‘diagnosis’ cannot be made without the following conditions, he mentions, being met. The conditions Mynors-Wallis states are a thorough assessment of the physical, psychological and social issues which the patient is facing. He continues to state that the training of psychiatrists enables psychiatrists to be able to meet this criteria, and therefore, to be able to make a ‘diagnosis’. Mynors-Wallis continues to state that patients expect that diagnoses are made by experienced professionals who have knowledge of all three areas mentioned. The final statement provided by the Registrar indicates, to the researcher, that he does not want to commit himself, or the RCP, into stating which professions have significant knowledge in the three areas mentioned and perhaps was inserted as a desire to not become drawn into a conversation as to whether other professions should be able to make a psychiatric diagnosis.

The British Psychological Society (BPS) email reply (appendix 8) included a link to a document published by the BPS Professional Practice Board written on 24th January 2013 entitled ‘Diagnosis – Policy and Guidance’. Section 3.1 states “The policy applies across the profession and should be applied by members, committee

members and representatives of the Society”. This affirms that the document is relevant to all the different divisions within the BPS: Academia, teaching & research; Clinical; Counselling; Educational; Forensic; Health; Neuropsychology; Occupational; Sports & exercise & Scottish division of education. Section 4.2 denotes that psychiatric diagnosis is commonly based upon the ICD-10 and the DSM which shows the psychiatric disorder categories they are promoting. Section 4.4 states:

“Practitioner psychologists may identify and record one or more mental and behavioural disorders relating to each individual as necessary, using standard diagnostic classification systems, and record these in client records, either on electronic systems or in paper notes. They may also use them in reports to the courts or other agencies” (BPS, 2013).

The BPS policy is stating that all divisions within the BPS may provide a psychiatric diagnosis within the ICD10 or DSM. The researcher wanted to identify whether the training of psychologists, in any division, equips them with the knowledge that the RCP states is required to make a diagnosis. After a further email from the BPS (appendix 9) the researcher was advised that their training does not equip them with the knowledge to be able to make an assessment of a patient’s physical issues, however may equip them with the skills to work with the psychological impacts of physical health. Thus, the basis for a counselling psychologist is not sufficient enough, in the opinion of the RCP, to make a psychiatric diagnosis. The RCP states that patients expect diagnosis to be made by professionals who have knowledge in this area. This implies that not only does the RCP believe that psychologists should

not provide psychiatric diagnoses; they are also not meeting the expectations and requirements of patients.

The researcher believes, due to the fact that the RCP and BPS do not appear to agree on who should make a psychiatric diagnosis, and also do not agree on what components are important to be assessed in order to make the diagnosis, increases the reasons for counselling psychologists Ruby and Jenny to have conflicting views. Perhaps this confusion provides another rationale as to why there appears to be an ongoing debate in respect to the topic.

This finding also led the researcher to identify that it is less clear for the counselling psychologists, in terms of who can make a psychiatric diagnosis, than for the psychotherapists.

5.2 IPA within the study

The method chosen to complete the first two parts of the study enabled detailed accounts of the participants' lived experiences surrounding the research question to emerge. An important rationale for selecting IPA involved the ability of the researcher questioning whether it was possible to bracket out his experiences and how this may impact upon the study. The researcher also raised the problems associated with making himself central to the research and whether this would help illuminate the subject. IPA appeared, at the time, to take a middle ground due to its

philosophical roots, which incorporated the researcher's interpretations. During the first interviews, which were with the psychotherapist participants, the researcher became curious as to whether the second interview perhaps had been influenced by the first and the third influenced by the first and second and so on. This influence could imply that the first interview was least influenced and opened up a question as to whether all that followed were further removed from the participants' lived experiences.

This possible limitation was also taken into consideration when deciding how to approach the second part of the study. The question arose as to whether the interviews and findings from the first part could influence the second part. The researcher chose to not revisit the first study in an attempt to bracket out these findings. Another option would have been to immerse oneself in the first study in an attempt to be more aware of the bias and influence. Both options seemed to have similar limitations, in that it is impossible to completely bracket out experience. The influence and bias appeared to be more pronounced during the second study, for the fact that each interview had been influenced by the previous as well as the first study's interviews and analysis. Looking back at the literature surrounding IPA in relation to these limitations, it became apparent that it was not limited to this study, and there were conflicting ways of addressing the limitation. Pringle *et al* (2011) quote Smith *et al* (1999) in which it is written that themes from the first interview can be carried forward and built on in subsequent accounts. Continuing to quote Smith *et al* (2009) where he emphasised the need to approach each case "on its own terms to do justice to its own individuality", he does acknowledge the difficulty in doing so, however there appears to be a contradiction with regard to how this

limitation can be addressed. Pringle suggests the fact that the two quotes are ten years apart implies the evolving nature of this research method. This limitation may also be present for the majority, if not all, qualitative methods that do not concentrate on a single case study.

Upon completion of the analysis, the researcher questioned whether he had stretched specific aspects of the data too far with regard to some of his interpretations. The researcher wondered whether he had moved away from the hermeneutics of trust into one more aligned with suspicion. An example of this could be seen in relation to Jenny and the researcher hypothesising that even though she states she enjoyed her training as a counselling psychologist she wished that she had trained to be a clinical psychologist or possibly as a psychiatrist. This perhaps could be more influenced by the researcher's own bias and experiences, and could also be seen as a limitation of IPA.

Another possible limitation of IPA was in regard to implementing a process for conducting phenomenological research. The notion of processes that one adheres to appears to be at odds with phenomenology. Smith *et al* (2009) stressed that IPA is non prescriptive and be adapted to fit with the research. This appears to acknowledge this potential limitation and enable more flexibility than other methods may permit, however, it does not escape from the fact that adhering to any set structure may close down possibilities.

The researcher chose to select only female counselling psychologists for inclusion in the study based upon the fact that only female psychotherapists participated in the first study. The researcher felt confident at the time that this would be more

beneficial than leaving the inclusion criteria open for both male and female participants for the reason that it would offer an overarching homogeneity within the study, therefore providing a robust case for conducting the comparison study. Upon completion of the study, there appears to be a strong argument that this decision could be seen as an attempt to control variables within the study. According to a comparison of qualitative and quantitative research Pappas & Tucker-Raymond (2011:6) Qualitative research “Explores naturalistic settings without controlling variables”. The researcher questions his decision to exclude male participants as this, perhaps, took the study away from the qualitative and phenomenological standpoint that was originally intended. The fact that the study made a specific point of only containing female participants may also be seen as an attempt to make generalisations of the group as an accurate representation of female psychotherapists and counselling psychologists which it did not set out to do. This also, perhaps, could be seen as taking the study further away from the phenomenological inquiry that was initially planned.

5.3 IPA findings as a comparison tool

The study was interested in the possibility of utilising IPA as a comparison tool. The researcher identified two studies Mitchie *et al* (2003) and Mitchie *et al* (2004) that had attempted to make comparisons within an IPA study, however, there did not appear to be a clear method to do so. There also did not appear to be any discussion as to the possible strengths and limitations of using IPA in this manner. The researcher had identified potential dangers of attempting to use IPA as a comparison tool; Heffron & Gil-Rodriguez (2011) wrote “Making a comparison within an IPA

study is actually quite difficult to achieve”. They later continue to provide the rationale for the difficulties in that they require a greater number of participants than normally used for IPA and that comparison studies “...therefore tends to result in studies that are primarily descriptive and lack depth”. The researcher did not want the study to be lacking in depth and did not want the study to simply describe the differences, instead the study aimed to highlight the similarities and differences based upon the lived experiences. The researcher chose to continue to explore whether there was the possibility of using IPA as a comparative tool despite the objections from a number of writers yet to remain true to IPA’s commitment to exploring participant’s lived experiences and not become entrenched in a quantitative study. Therefore, this study attempted to develop a new method to explore whether this was possible with a view that, if successful, it could be the first step in being used within further IPA studies. The researcher chose to concentrate on the findings obtained from the two IPA studies in order to identify potential similarities and differences, and then revisit the data to explore whether this was backed up by the original text. This enabled several similarities and differences to be identified. Therefore, this displayed that IPA can be used in order to help compare groups. The study highlighted interesting similarities and differences between these two groups of participants that may not have been identified by completing the two different IPA studies and not completing a comparison study. The comparison method appeared to have its own limitations which may benefit by being adapted for further research.

The limitation surrounding how interviews and studies are influenced by previous interviews and studies has been discussed previously. In addition, there appeared to be further limitations including:

- By initially concentrating on the themes which had emerged from the two IPA studies and not revisiting the entire data could mean that significant comparisons were not able to emerge.
- Upon revisiting the data, in an attempt to determine if the differences from the sub theme tables were actual differences when analysed within the raw data, the researcher became aware that he was specifically searching for something to justify this. There were specific aspects of the data which the researcher identified which fitted into a sub theme, however, upon re-reading, felt had been stretched too far from the original meaning. IPA embraces the researcher's interpretations; although it is essential to not take the interpretations too far from the original text. The researcher believes this may be a possible reason as to why more similarities emerged than differences.
- One specific problem with any form of comparison is the control of external variables (Doll & Hill 1950) which may impact and influence the study. These external variables can be known or unknown, therefore the differences that the study identified, may not be related to the different professions, instead could be an unknown variable that the study was not able to identify. For example, the study highlighted one of the differences as the counselling psychologists spoke about the economic pressures that may influence the use of psychiatric diagnosis, and the psychotherapists did not. This could be due to a number of reasons including:

1. The counselling psychologists' training enabled them to be aware of the economic pressures' effect on psychiatric diagnosis, whereas the psychotherapists' training did not.
2. The economic pressure influenced the training of the counselling psychologists and not the psychotherapists' training
3. An unknown variable was the cause for the counselling psychologists to be able to speak of the economic pressures, and the psychotherapists to not be able to do so. The researcher hypothesised that this unknown variable could perhaps be that the interviews were conducted two years apart and possibly there has been less spending, both privately and publically, on mental health. Another possibility could be that half the counselling psychologists spoke about working within the NHS, and perhaps psychotherapists do not work in the NHS.

The researcher did, however, find that, by attempting to compare the two sets of findings, more findings emerged regarding Jenny's position on psychiatric diagnosis. This was of particular interest, as the researcher was unsure as to why these findings did not appear to him when he was conducting his original IPA analysis of the counselling psychologists. This opened up a question as to whether the more time one spends analysing data could influence the findings. Perhaps the findings are always fluid and by attempting to compare, simply highlighted that to the researcher. One possible rationale as to why these findings did not emerge originally, could be related to the lens that the researcher adopts when conducting any piece of research, perhaps by looking to identify similarities and differences enabled a different lens in

which to view the data, to emerge. Another possible rationale could be in relation to the time and place of the researcher. Both these possible reasons could also be true of any form of phenomenological research. This led the researcher to question whether the actual process of conducting this study has been more important than the findings, which led him to look at his role within the study.

The researcher believes the key learning from undertaking the comparison study includes:

- IPA can be used as a tool for comparison, however, as mentioned in previous literature, the study can become more descriptive than a traditional IPA study.
- Using IPA as a comparison tool can enable a different lens to be adopted for looking at the data obtained during the original studies, therefore could be used not only as a comparison tool, but as a tool for providing further insight and interpretation of the original data.
- There are significant limitations to using IPA as a comparative tool, as previously stated.
- There is the potential to attempt to control variables in order to be able to complete the comparison study, moving away from a qualitative approach into a more pluralistic one.
- The design stage of the comparison study is fundamental to whether the study could stand up to rigour. The fact that the researcher did not fully explore and address the critique for adopting an all female inclusion criteria in the original study also had implications when it came to the comparison study. The researcher recommends revisiting the rationales stated for the original studies prior to agreeing the design of the comparison study.

5.4 Role of supervision and personal therapy

Throughout the study, the researcher had been in regular supervision and weekly personal therapy. These two therapeutic places provided significant input into the study, including the conception and discussion. The researcher's personal therapy had remained constant in that he had worked with the same psychoanalyst throughout his entire training and the length of the study. His supervision had differed in that, during the first year of training it was facilitated by a person centred counsellor. In his second year of training, supervision was provided by a psychoanalyst. From the middle of the third year, the researcher changed supervisor and remained in supervision with this psychoanalyst for the remainder of the study. Upon completion of the study, the researcher acknowledges the importance of both personal therapy and supervision, often finding specific topics surfacing during supervision which were then taken into personal therapy to explore further. These topics included feelings arising from referral letters and potential client's psychiatric diagnoses. The researcher is aware, once again, of his frustrations of speaking about psychiatric diagnosis in therapy, and perhaps can see that he wanted more guidance. This highlights the researcher's anxieties further, and his desire to be told how to be, rather than finding out for himself and learning from experience.

The researcher felt the importance of acknowledging the differing, and often conflicting, messages that came from supervision. At first glance, the researcher wondered if this was due to having two different modalities within his supervision during his training. The person centred approach and a psychoanalytical one. The researcher recollects feelings of confusion trying to please both supervisors. The

researcher recalls how he felt his person centred supervisor would often shut down conversations surrounding psychiatric diagnosis, leading to a sense of not being able to bring up the topic. In psychoanalytical supervision the topic arose more often, the message was more to do with not working with the psychiatric diagnosis; however, exploration felt more permitted than before. Often the conclusion surrounding the discussions highlighted issues that were important and perhaps, needed further exploration in personal therapy. This suggested that different modalities, perhaps have different opinions on the use of psychiatric diagnosis, and suggested that further research could be beneficial, comparing different modalities of psychotherapists in relation to the question asked in this study.

The different modalities were not the only source of confusion, the fact that different people within the same modality appeared, to the researcher, to have different opinions, also seemed to raise the researcher's anxieties. Interestingly, the researcher found that each supervisor would, at times, seem to contradict themselves in relation to the use of psychiatric diagnosis. This suggested to the researcher that the outlook on psychiatric diagnosis may also be influenced by each person's own lived experiences, including the fact that people's opinion is fluid and can change. These points added to the researcher's confusion and, perhaps, provide more rationale as why the researcher chose the topic for his study.

The researcher believed it was important that each of the participants were in regular supervision. One reason was to ensure that all of the participants had a therapeutic space to be able to take any issues that possibly could have arisen during the interviews. Secondly, the researcher was of the opinion it was important for all participants to have had a supervisory space where personal bias may have been challenged. As mentioned above, people's opinion on the use of psychiatric

diagnosis varied by different people, even if they are of the same therapeutic orientation, therefore, it was essential that the participants were in supervision to be able to discuss their client situations viewed from another lens, which may also include a different viewpoint in relation to diagnosis.

5.5 Implications for practitioners and trainers

The findings from this study aim to add to the knowledge pool surrounding the historical and ongoing debate regarding psychiatric diagnosis. The key findings highlight different ways in which psychiatric diagnosis and the medical model can potentially lead to not seeing a person as a human being, rather as a set of symptoms to be treated. The study also demonstrates how psychiatric diagnosis can be used inappropriately, for example, as a tool to choose not to work with someone, or to access state or insurance funding. The findings suggested that, for the counselling psychologists, there often appears to be a ‘treatment plan’ for different psychiatric diagnoses, and this highlights a possible conflict for counselling psychologists in how they work, as this seems to be at odds with the therapeutic relationship being at the value base of counselling psychology that the BPS (2006) mentions. It is also important to recognise that this was not only present for the counselling psychologists as a number of the psychotherapists interviewed also appeared to have a specific way of working based upon the diagnosis provided. The limitations and potential problems with psychiatric diagnosis are discussed, and the researcher hopes the findings can enable practitioners to think about where they are in relation to psychiatric diagnosis, to possibly introduce the notion that there are alternatives to

the medical model and to be open to questioning dominant discourses rather than simply accepting them.

The researcher believes that his journey with the topic of psychiatric diagnosis is also an important aspect in relation to the implications for practitioners and trainers. The study has shown how the researcher's viewpoint on psychiatric diagnosis has changed over time; the researcher believes that immersing himself in a study relating to this topic has helped facilitated this significant change. The researcher's personal therapy has also enabled further self-awareness in respect to his position of psychiatric diagnosis, and considers this to have been an important aspect of his professional training.

The researcher also believes the study highlights the importance of training programmes to include elements specifically designed to question the use of psychiatric diagnosis and look at alternatives to the medical model. In addition to providing critical thinking in relation to psychiatric diagnosis, the study highlights the importance of critical thinking with regards to all aspects, in hope that this could help prevent traditional or folk models being taught as the only model to future practitioners.

5.6 The researcher's role within the study

Griffin (2004) wrote: "The dominant positivist approach to doing research from a psychological perspective treats researchers as apolitical, emotionally distanced and unbiased beings". However, upon completion of the study, the researcher found the most fundamental issue he experienced was in regard to being able to bracket out

specific aspects of his experience. He was aware of this when debating which method to use, as outlined in the methodology chapter. The researcher did not fully consider the different ways in which this could impact upon the study until its completion, and all but one has been discussed earlier within this chapter. The researcher's own experiences and bias had not been fully appreciated until the completion of the study. The researcher came from a specific place when attempting the first part of the study in 2012. He had been working within psychiatric hospitals since 2005. All patients were under the care of a psychiatrist, and treatments were prescribed based upon the assessment and diagnosis which was conducted by the psychiatrist. The researcher had often heard members of the clinical team, as well as those in other departments, including housekeeping and administration, using diagnostic terminology and, on many occasions, in a derogatory manner. This way of working appeared to be at odds to the phenomenological approach of the professional training he was undertaking at the time. The first year of his training was concerned with the works of Carl Rogers and person centred counselling. As discussed in the literature review, Rogers was strongly opposed to any form of diagnosing as it takes away from the experience of the individual. The researcher was still working in a psychiatric setting during the training and this became extremely confusing as both views appeared to be in direct opposition. As outlined in the introduction, during the researcher's first few months of training, he was asked to see a woman for counselling who had recently suffered bereavement. Attached to the referral letter was a note from the GP stating the patient had a historical diagnosis of personality disorder. The researcher was strongly influenced by the sticky note and the diagnosis mentioned. It had influenced the way he worked and how he saw the patient. This experience had become a major reason why he chose the topic for

this study. He worked with the client and was confused as to why the psychiatric diagnosis had impacted the way he worked and felt angry towards himself for making prejudgements based upon these two words. Initially the researcher commenced the study looking to see whether other psychotherapists had similar experiences, however, upon reflection, the researcher is able to consider that, perhaps, he was wrestling with finding his own viewpoint regarding the use of psychiatric diagnosis. This struggle may have been influential to all aspects of the study. The researcher considers that his approach to locating literature within the literature review has been influenced by his struggle. The literature highlighted authors that appeared to be for, against or took a middle ground towards psychiatric diagnosis. However, the researcher found it difficult to identify the ones who took a middle ground, it was easier to identify those for and against. This, perhaps, indicates another dimension to the struggle he faced, it is possible that the researcher believed it had to be black or white; for the use of psychiatric diagnosis or against. This, possibly, led the researcher to undertake the research in order to find where he stood on the topic. Upon reflection, the researcher believes he found it difficult to accept some of the reasons for using psychiatric diagnosis as well as some of the reasons not to use it. This may have resulted in possibly looking for others to be in a similar predicament which indicates a bias that, perhaps, was present throughout the entire study. The researcher hypothesises that he found it disturbing to not be able to understand his position in relation to psychiatric diagnosis and was possibly searching for his position to be fixed. This echoes the work of Cayne (2013) where she writes about the need to make generalisations in an attempt to reduce anxiety. It also highlighted the researcher's desire to understand the authorities' position in relation to this topic, which, once more, demonstrates how uncomfortable it has

been, having his place of work holding a perceived viewpoint which contradicted his perception of the training course's viewpoint. The researcher identifies that his desire was to follow the established opinion on the matter rather than finding his own. An interesting finding which emerged from the study helped the researcher to identify this possibility. The findings suggest a number of participants' positions, regarding psychiatric diagnosis, appeared to have changed since completion of their training. However, it did not appear they had abandoned the beliefs founded during training; instead, the impression presented is that the participants incorporated their training with their experiences as a practitioner, and their viewpoint had evolved.

The researcher has previously provided a critique of the comparison study which was undertaken and the perceived issues and limitations with doing so. One interesting aspect which emerged was how new features of the data emerged upon revisiting the raw data. For example, significant and relevant aspects of Jenny's position regarding psychiatric diagnosis emerged during the comparison study that had not done so during the original analysis. This opened up the question as to whether other information remained hidden, and perhaps, further analysis or another comparison may be necessary. This raises an issue surrounding qualitative research in general. It is the responsibility of the researcher to attempt to uncover the relevant data within a specific set method. Perhaps the method itself can hinder what would emerge naturally, as previously discussed. The researcher wondered if there was a parallel process emerging; having a set method to work from prompted the researcher to recall how the counselling psychologists would use a psychiatric diagnosis, provided prior to seeing the patient, to identify a treatment plan or model with which to work. Also, how the psychotherapists appeared, from the findings, to act in a similar

manner, except they do not explicitly say so. By adhering to the method for the study, the researcher identified significant and relevant aspects which, perhaps, could not emerge, possibly the same could be said for the work with the counselling psychologists' and the psychotherapists' patients, the treatment plan may not allow for significant and relevant aspects to emerge. Kathy's words may have alluded to this potential issue: "it is very important to be able to park that to keep it in mind but to not really let that come the centre of the work" (Kathy P6, L21-22)

There has been significant personal and professional learning for the researcher throughout the course of conducting the study; one of the most profound being in regard to how we learn. His position in relation to psychiatric diagnosis prior to his professional training was influenced by the organisation he worked for. The perceived position adopted by his professional training was one held by the modalities that were studied and literature read. The anxiety experienced by the researcher upon commencing clinical work perhaps was due to the incompatibility of the two positions and how the researcher believed they were fixed positions. The study appears to be an attempt to reduce the researcher's own anxieties with an aim of learning from experience as opposed to what is taught. It has become apparent that attempting to find the 'correct' position on psychiatric diagnosis perhaps is also part of the problem. The researcher was trying to reduce his anxieties by making a generalisation, perhaps a better place for the researcher to sit is with the unknown. The researcher can never fully understand the experience of the other, therefore, accepting this is important in relation to clinical work and also in relation to the study. The study has enabled the researcher to appreciate the importance of not

knowing, both in professional and personal life. The words of Brew (1993:88) resonated:

“I’m inclined to say that it is the process of learning that is important, that there is only the journey, never the destination. However I think what I am referring to is the process of unlearning: the attempt to access our inner knowings; the coming face to face, again and again with our ignorance; with our not-knowing. The highest point of knowing is not knowing. Herein lies the paradox of learning from experience.

After completing this study the researcher chose to review his experience with psychiatric diagnosis. Whilst still unsure of exactly his thoughts on the subject, it had become apparent that, ‘not knowing’ is not as a bad a place to be as originally thought. In fact, the researcher believes that the attempt to find a fixed position was an attempt to alleviate his anxieties surrounding the subject, meaning that it is more to do with him and his worries than the subject itself. One of the findings from the study showed how many of the benefits of using psychiatric diagnosis are for the clinician rather than the patient and the researcher argues that this is also a way of the clinician dealing with their own anxieties. The researcher aims to not see psychiatric diagnosis in the same way that he once did, at the commencement of his training, instead, to see the person sitting opposite him as a human being with the deciding factor to choose to work with that person to not be based on any words of a diagnosis, instead based on asking himself if he has the courage to work with the person.

5.7 Suggestions for further research

This study aimed to explore in what ways, if any, psychiatric diagnosis influences the way psychotherapists and counselling psychologists work. It investigated the lived experiences of these two groups in relation to the research question and identified potential similarities and differences. Further research building on this study could include asking the same question to psychiatrists, or perhaps asking about how an externally provided psychiatric diagnosis influences the way in which they work. This sample group was originally not chosen as suitable when contemplating this study. However, in light of the sub theme of economic pressure emerging for the counselling psychologist participants and the possible interpretation that this perhaps is due to working at some point within the NHS, would mean that it would be interesting to explore whether psychiatrists also spoke about this pressure. From a methodological perspective, further research could build on the comparison method outlined in this study, for example, an investigation exploring whether other qualitative methods such as grounded theory or heuristic inquiry could be used as a comparison tool. Furthermore, a pluralistic methodological approach could be adopted comparing the similarities and differences between different methods. This could provide different insights into the question being investigated. Josselin (2013) writes:

“qualitative pluralism offers a multifaceted way to engage with subjectivity and meaning – making. It can deepen the way one thinks

about the lived experience and its communicability, and as such may hold particular value for those engaged in therapeutic work”.

By adopting a comparison after the pluralistic analysis, there could be the potential to illuminate the methodological similarities and differences as well.

6. CONCLUSION

The study implies the impossibility for psychotherapists and counselling psychologists to escape from the use of psychiatric diagnosis due to the fact that it is the dominant discourse within psychotherapeutic work. All the clinicians involved in the study were able to discuss the potential benefits and disadvantages of its use, and all indicated they are influenced, to some extent, by its presence even if they believe they are not. A number of the benefits and disadvantages mentioned within the literature were described by the participants as they explored their lived experiences. The implications of psychiatric diagnosis can be life changing for people, with the study highlighting that certain rights, often taken for granted, can be revoked due to a psychiatric diagnosis. Society has moved away from a time where homosexuality was considered a psychiatric illness, where specific civil rights were denied because of the label. However, the researcher wonders if the use of labels can allow this to occur again or perhaps it already has, possibly we see specific diagnoses the same way as people once saw homosexuality, albeit in a very different manner.

The study also highlighted that it can, under specific conditions, be in both the interest of the clinician and the patient, for the patient to be diagnosed incorrectly, in order to access funding or services otherwise not available to them, highlighting that the psychiatric diagnostic system is open to abuse.

The study provided another aspect to the ongoing struggle regarding psychiatric diagnosis as two of the leading governing bodies within mental health, the Royal College of Psychiatry and the British Psychological Society, appear to take a different stand as to what criteria is needed in order to come up with a psychiatric diagnosis for a patient, and who can make it. The researcher believes that if these two bodies cannot agree on what constitutes a psychiatric diagnosis then there will continue to be ambiguity surrounding healthcare professionals' opinion on the topic.

For the researcher, an important conclusion has been identified, which is to acknowledge someone's position regarding psychiatric diagnosis is not a fixed one, and, perhaps, is always evolving and adapting. Therefore, this study will add to the researcher's experience and training in relation to psychiatric diagnosis and will contribute to, hopefully, finding a position to comfortably call his own, accepting that this can change over time.

6. BIBLIOGRAPHY

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